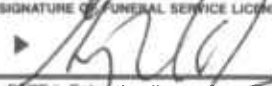
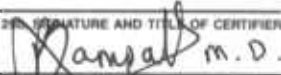



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HARRIET KAGAY				2. DATE OF DEATH MONTH 11 DAY 24 YEAR 95		3. TIME OF DEATH 5:39 A.M.	
4. SOCIAL SECURITY NUMBER 274-10-1080		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 3, 1913	
8. BIRTHPLACE (State or Foreign Country) Ohio				9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins University - Bayview		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE FL		10b. COUNTY Maratee	
10c. CITY, TOWN OR LOCATION Bradenton				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 9418 Concord Circle	
10f. ZIP CODE 34210				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY home	
17. FATHER'S NAME (First, Middle, Last) Elmer Ellsworth Swain				18. MOTHER'S NAME (First, Middle, Maiden Surname) Kate Cain			
19a. INFORMANT'S NAME (Type/Print) Stephen W. Kagay				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 948 Glenangus Dr., Belair, MD 21015			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) The Green Mount Cemetery 11/28		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227			
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. presumed aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. brain tumor DUE TO (OR AS A CONSEQUENCE OF): c. hydrocephalus DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <1h unknown 6 mons.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER  CHIEF RESIDENT				29c. LICENSE NUMBER AJ4147357		29d. DATE SIGNED (Month, Day, Year) 11/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PRAKASH SAMPATH JOHNS HOPKINS BAYVIEW, DEPT. NUS							
31. DATE FILED (Month, Day, Year) NOV 29 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36002

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPHINE L. KUCHERER				2. DATE OF DEATH MONTH NOVEMBER DAY 23 , YEAR 1995		3. TIME OF DEATH 0955 M	
4. SOCIAL SECURITY NUMBER 218-18-8550		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 17, 1921	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Randallstown	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Randallstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 10114 Liberty Road	
10f. ZIP CODE 21133				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Arthur Wingfield				18. MOTHER'S NAME (First, Middle, Maiden Surname) Caroline Page			
19a. INFORMANT'S NAME (Type/Print) Mrs. Dolores Speelman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1056 Deer Park Road Westminster, MD 21157			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation, Inc. 11/25		20c. LOCATION — City or Town, State Hampstead, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James B. Corcoran				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE RESPIRATORY FAILURE Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. COPD c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER C. Navi MD				29c. LICENSE NUMBER D 37333		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 23, 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. RAVI, MD, NHC, BALTIMORE, MD 21133							
31. DATE FILED (Month, Day, Year) NOV 29 1995				32. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020


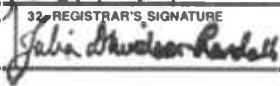
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36003

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth A. Koch				2. DATE OF DEATH MONTH DAY YEAR Nov. 23, 1995		3. TIME OF DEATH 7:20 A M	
4. SOCIAL SECURITY NUMBER 217-07-2762		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 6, 1916	
9a. FACILITY NAME (If not institution, give street and number) 8504 Woodfall Road				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3025 Mayfield Avenue				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Marco Scardina				18. MOTHER'S NAME (First, Middle, Maiden Surname) Vita Caruso			
19a. INFORMANT'S NAME (Type/Print) Loretta E. Knapp (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8504 Woodfall Road, Baltimore, Maryland 21236			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem. 11/25/95		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSER 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, MD 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pancreatic Carcinoma, Metastatic DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 6 weeks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Charles A. Padgett, MD					
29c. LICENSE NUMBER DISS46		29d. DATE SIGNED (Month, Day, Year) Nov 24, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles A. Padgett, MD, 5601 Loch Raven Blvd, Baltimore, MD							
31. DATE FILED (Month, Day, Year) NOV 2, 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36004

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Karpovich, Walter W.				2. DATE OF DEATH MONTH NOVEMBER DAY 24 YEAR 1995		3. TIME OF DEATH 4.00 A.M.	
4. SOCIAL SECURITY NUMBER 218-05-2418		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 28, 1921	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, MD.		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3511 Chesterfield Avenue				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 8th Grade				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Crane Operator		16b. KIND OF BUSINESS/INDUSTRY Steel Company	
17. FATHER'S NAME (First, Middle, Last) John Karpovich				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophie Iszkiewicz			
19a. INFORMANT'S NAME (Type/Print) Barbara F. Goodman (Niece)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4745 Columbia Road, Ellicott City, Md. 21042			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart of Jesus 11/27/95		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert Prodan</i>				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PULMONARY EDEMA							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. SMALL CELL LUNG CA							
DUE TO (OR AS A CONSEQUENCE OF):							
c. COPD							
DUE TO (OR AS A CONSEQUENCE OF):							
d. CHF							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HIGH BLOOD PRESSURE							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER D. JENAT, MD				29c. LICENSE NUMBER AT 2438946		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 24 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ZEINA JENAT, UNION MEMORIAL HOSPITAL, 201 E UNIVERSITY PKWY, BALTO, MD.							
31. DATE OF FILING (Month, Day, Year) NOV 29 1995		REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36005

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Minnie M. Lukenich				2. DATE OF DEATH MONTH DAY YEAR Nov. 27, 1995		3. TIME OF DEATH 3:00 a.m.		
4. SOCIAL SECURITY NUMBER 214-26-6599		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-30-27		
9a. FACILITY NAME (If not institution, give street and number) 102 S. Augusta Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A		
10a. STATE Md.				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 102 S. Augusta Ave.-Baltimore, Md.				
10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 8 College (1-4 or 5+) Brushmaker		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY Md. Brush Co.				
17. FATHER'S NAME (First, Middle, Last) Gabriel Lukenich				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Lange				
19a. INFORMANT'S NAME (Type/Print) Anna Lukenich				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 S. Augusta Ave.-Balto., Md. 21229				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cem. 11-30-95		20c. LOCATION — City or Town, State Balto., Md.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE G. Truman Schwab				22. NAME AND ADDRESS OF FACILITY 3512 Frederick Avenue Baltimore, Md. 21229				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → ENDOMETRIAL CANCER DUE TO (OR AS A CONSEQUENCE OF):								
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER 040012		29d. DATE SIGNED (Month, Day, Year) 11/29/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Scott Boulton, 4600 Wilkes Ave, Suite 107, Baltimore, MD 21229								
31. DATE FILED (Month, Day, Year) NOV 29 1995				32. REGISTRAR'S SIGNATURE [Signature]				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36006

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES Gardner LAWSON				2. DATE OF DEATH MONTH DAY YEAR November 22, 1995		3. TIME OF DEATH 5:00 A M	
4. SOCIAL SECURITY NUMBER 214-14-0222		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 12, 1911	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Meridan Nursing Center-6000 Bellona		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH n/a				10a. STATE Maryland		10b. COUNTY n/a	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 2314 Edgemont Avenue	
10f. ZIP CODE 21217				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Baltimore City Public Sch	
17. FATHER'S NAME (First, Middle, Last) Winston Lawson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosie			
19a. INFORMANT'S NAME (Type/Print) Mary Charlene Love				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1223 Sharonton Drive Stone Mountain, GA 30083			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park		20c. LOCATION — City or Town, State 28 Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin Parker				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Acute pulmonary thrombosis b. Deep vein thrombosis c. Symptomatic d. Thrombophlebitis							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes was Diagnosed DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. M. A. Brown				29c. LICENSE NUMBER DI 18467		29d. DATE SIGNED (Month, Day, Year) 11/22/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. M. A. Brown 301 St. Paul Place Suite 217							
31. DATE FILED (Month, Day, Year) NOV 29 1995				32. REGISTRAR'S SIGNATURE Julia Anderson-Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36007

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) CHARLES VICTOR LEWIS, Sr.				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 22 1995		3. TIME OF DEATH 10:13 A M	
4. SOCIAL SECURITY NUMBER 215-30-7794		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN 2, 1935	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEASED							
10a. STATE Md.		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Ellicott City		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8590 Horseshoe Rd.				10f. ZIP CODE 21043		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) N/A		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Heavy Equipment Sales		16b. KIND OF BUSINESS/INDUSTRY Self-employed			
17. FATHER'S NAME (First, Middle, Last) Henry J. Lewis, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Cooper			
19a. INFORMANT'S NAME (Type/Print) Shirley G. Lewis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8590 Horseshoe Rd., Ellicott City, Md. 21043			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 11/28		20c. LOCATION — City or Town, State Elkridge, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. Premature aging DUE TO (OR AS A CONSEQUENCE OF): d. CHF. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. copp							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Mohammad Saleem				29c. LICENSE NUMBER D40610		29d. DATE SIGNED (Month, Day, Year) November 22 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOHAMMAD SALEEM, St. Agnes Hos., 900 S. Caton Ave., Balto. MD 21229							
31. DATE NOV 29 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36008

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Edward Joseph Lavandor</i>				2. DATE OF DEATH MONTH <i>11</i> DAY <i>27</i> YEAR <i>95</i>				3. TIME OF DEATH <i>9A</i> M	
4. SOCIAL SECURITY NUMBER <i>219 18 6806</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <i>75</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>05 16 20</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>824 South Rappolla Street</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>				9c. COUNTY OF DEATH <i>N/A</i>	
RESIDENCE OF DECEDENT									
10a. STATE <i>Md.</i>		10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>824 S. Rappolla Street</i>				10f. ZIP CODE <i>21224</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>W.W. 2</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Security</i>			16b. KIND OF BUSINESS/INDUSTRY <i>Chemical</i>		
17. FATHER'S NAME (First, Middle, Last) <i>Edward J. Lavandor</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Rosalie Stachorowski</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Lorna L. Jones</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>205 Yoakum Parkway Alexandria, Va. 22304</i>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Maryland Veterans Cem.</i>		DATE <i>11-29-95</i>		20c. LOCATION — City or Town, State <i>Garrison Forest Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles S. Zeiler</i>				22. NAME AND ADDRESS OF FACILITY <i>Charles S. Zeiler & Son Inc. 6224 Eastern Ave. Balto., Md.</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CVA</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>Atrial fibrillation</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Tobacco did contribute</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Finucane</i>				29c. LICENSE NUMBER <i>D24334</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/28/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>FINUCANE MD JHGC</i>									
31. DATE FILED (Month, Day, Year) <i>NOV 24 1995</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36009

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FAITH NICOLE METZ				2. DATE OF DEATH MONTH November DAY 19 YEAR 1995		3. TIME OF DEATH 6:12 p. M					
4. SOCIAL SECURITY NUMBER unknown		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN. 24		7. DATE OF BIRTH (Month, Day, Year) Oct. 26, 1995		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not Institution, give street and number) 2622 Merrick Way				9b. CITY, TOWN OR LOCATION OF DEATH Abingdon				9c. COUNTY OF DEATH Harford			
RESIDENCE OF DECEDENT											
10a. STATE Pennsylvania		10b. COUNTY Franklin		10c. CITY, TOWN OR LOCATION Chambersburg				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 48 Eton Court				10f. ZIP CODE 17201		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A					
17. FATHER'S NAME (First, Middle, Last) Lonnie Shane Metz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Stacy Lynn Baker							
19a. INFORMANT'S NAME (Type/Print) Lonnie S. Metz (Father)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 Eton Court, Chambersburg, Pa. 17201							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Most Holy Redeemer Cem. 11/22/95		DATE 11/22/95		20c. LOCATION — City or Town, State Baltimore, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Trisomy 18 DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 24 days			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED N/A			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Lugh Anne Achem, MD						29c. LICENSE NUMBER D44200		29d. DATE SIGNED (Month, Day, Year) 11-21-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4 Vale Rd, Bel Air, MD 21014											
31. DATE FILED (Month, Day, Year) NOV 2, 91995					32. REGISTRAR'S SIGNATURE 						

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 36010

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET LOUISE MAKLE				2. DATE OF DEATH MONTH 11 DAY 16 YEAR 1995		3. TIME OF DEATH 8:45 P M	
4. SOCIAL SECURITY NUMBER 220-12-8645		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5 3 25	
8a. FACILITY NAME (If not institution, give street and number) 4035 HILTON ROAD				8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		8c. COUNTY OF DEATH N/A	
9. RESIDENCE OF DECEDENT				10a. STATE MARYLAND		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 4035 HILTON ROAD	
10f. ZIP CODE 21215				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 8+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BEAUTICIAN		16b. KIND OF BUSINESS/INDUSTRY HAIR CARE			
17. FATHER'S NAME (First, Middle, Last) ROBERT GREEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) RACHEL CARTER			
19a. INFORMANT'S NAME (Type/Print) JACQUELINE KIDD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 WESTERN WINDS CIRCLE 21244			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) ARBUTUS MEM. PARK 11/21		20c. LOCATION — City or Town, State ARBUTUS, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dorothy Hester CFSP #281				22. NAME AND ADDRESS OF FACILITY E.L. PHILLIPS FUNERAL HOME 1721-27 N. MONROE STREET			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → myocardial infarction Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Chronic renal failure							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER C.D. Kearney MD				29c. LICENSE NUMBER D27860		29d. DATE SIGNED (Month, Day, Year) November 21, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHRISTOPHER D. KEARNEY MD 700 WASH BLVD BALT MD							
31. DATE FILED (Month, Day, Year) NOV 29 1995		32. REGISTRAR'S SIGNATURE J. H. [Signature] 21230					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Francis Mulligan				2. DATE OF DEATH MONTH DAY YEAR Nov. 26 1995		3. TIME OF DEATH 8:35 P. M.	
4. SOCIAL SECURITY NUMBER 165-22-9826		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH Day, Year Sept. 21, 1930	
9a. FACILITY NAME (If not institution, give street and number) 910 Stamford Road				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 910 Stamford Road				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales		16b. KIND OF BUSINESS/INDUSTRY Insurance Industry	
17. FATHER'S NAME (First, Middle, Last) Frank Mulligan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cecilia Luther			
19a. INFORMANT'S NAME (Type/Print) Christine Mulligan (Spouse)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Stamford Road Baltimore, Maryland 21229			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Nov. 30, 1995 St. John's Cemetery		20c. LOCATION — City or Town, State Ellicott City, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Carcinoma of Prostate							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D08780		29d. DATE SIGNED (Month, Day, Year) 11/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Alejandro Mejia M.D. P.A. 405 FREDERICK RD STW CATONSVILLE MD							
31. DATE FILED (Month, Day, Year) NOV 29 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>James T. Martin</u>				2. DATE OF DEATH MONTH DAY YEAR <u>Nov. 27, 1995</u>		3. TIME OF DEATH <u>8:35 a.m.</u>	
4. SOCIAL SECURITY NUMBER <u>247-46-4939</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <u>66</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>11-01-29</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>1704 Chesterton Road</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Chadwick</u>		9c. COUNTY OF DEATH <u>Baltimore</u>	
10a. STATE <u>Md.</u>		10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Chadwick</u>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>1704 Chesterton Rd.-Baltimore, Md.</u>				10f. ZIP CODE <u>21244</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>Korean War</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (8-12)</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Capitol Police</u>		16b. KIND OF BUSINESS/INDUSTRY <u>U.S. House of Representatives</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Frank W. Martin</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Ida C. Longshore</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Regina T. Martin</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1704 Chesterton Rd.-Balto., Md. 21244</u>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>New Cathedral Cem. 11-30-95 Balto., Md.</u>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>G. Truman Schwab</u>				22. NAME AND ADDRESS OF FACILITY <u>5151 Baltimore National Pike Baltimore, Md. 21229</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>METASTATIC BREAST CANCER</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <u>15 YEARS</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>		29c. LICENSE NUMBER <u>D38409</u>		29d. DATE SIGNED (Month, Day, Year) <u>11/29/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>4940 EUREAN AVE BALTIMORE, MD 21224</u>							
31. DATE OF DEATH <u>NOV 29 1995</u>		32. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760


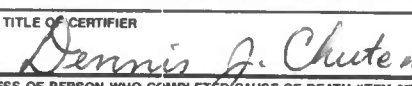
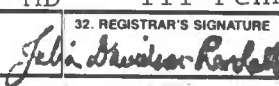
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES CALDWELL MURRAY				2. DATE OF DEATH MONTH DAY YEAR NOV. 19, 1995		3. TIME OF DEATH 19:25 P.M.	
4. SOCIAL SECURITY NUMBER 215-38-2492		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 6, 1941	
9a. FACILITY NAME (If not institution, give street and number) 5380 MORRIS DRIVE				9b. CITY, TOWN OR LOCATION OF DEATH CAMBRIDGE		9c. COUNTY OF DEATH DORCHESTER	
10a. STATE MARYLAND		10b. COUNTY DORCHESTER		10c. CITY, TOWN OR LOCATION CAMBRIDGE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5380 MORRIS DRIVE				10f. ZIP CODE 21613		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MECHANIC		16b. KIND OF BUSINESS/INDUSTRY FOOD PROCESSING			
17. FATHER'S NAME (First, Middle, Last) JAMES MURRAY				18. MOTHER'S NAME (First, Middle, Maiden Surname) THELMA MOLOCK			
19a. INFORMANT'S NAME (Type/Print) PAMELA THOMPSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5378 MORRIS DRIVE CAMBRIDGE, MD 21613			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) EAST NEW MARKET CEMETERY 11/25		20c. LOCATION — City or Town, State EAST NEW MARKET, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HENRY FUNERAL HOME 510 WASHINGTON ST CAMBRIDGE, MD 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 20, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Chute, MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 29 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36014

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William S. Musch				2. DATE OF DEATH MONTH DAY YEAR 11 27 95		3. TIME OF DEATH 11:38a	
4. SOCIAL SECURITY NUMBER 215-14-7793		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 2, 1922	
9a. FACILITY NAME (If not institution, give street and number) 426 S. Wolfe Street				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Md.				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 426 S. Wolfe Street			
10f. ZIP CODE 21231				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician		16b. KIND OF BUSINESS/INDUSTRY Plant Electrician			
17. FATHER'S NAME (First, Middle, Last) N/A				18. MOTHER'S NAME (First, Middle, Maiden Surname) N/A			
19a. INFORMANT'S NAME (Type/Print) Marie M. Rostek				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 426 S. Wolfe Street, Balto., Md. 21231			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart of Jesus Cem. 11/30		20c. LOCATION — City or Town, State Baltimore, Md.		20d. DATE 11/30	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Lilly & Zeiler Inc. 1901 Eastern Avenue 21231			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. Coronary Artery Disease							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. 20 yrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Anil Ubenor MD				29c. LICENSE NUMBER 026748		29d. DATE SIGNED (Month, Day, Year) 11/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANIL UBENOR 4419 FALLS RD BALTO MD 21211							
31. DATE FILED (Month, Day, Year) NOV 29 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

170710

NOV 28 1993

95 36015

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MIRIAM V. MORRIS				2. DATE OF DEATH MONTH 11 DAY 28 YEAR 95		3. TIME OF DEATH 9:58 AM	
4. SOCIAL SECURITY NUMBER 184-09-9128		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 3, 1902	
8. BIRTHPLACE (State or Foreign Country) Kansas				9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Center-Long Green		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 115 E. Melrose Avenue	
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Charles Van Horn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Lee Ragsdale			
19a. INFORMANT'S NAME (Type/Print) Jacob Drawbaugh				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3322 Gillis Falls Rd., Mt. Airy, Maryland 21771			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 12/1/95		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE A. Alan Seitz Jr.				22. NAME AND ADDRESS OF FACILITY A. Alan Seitz, Jr. Funeral Home 3818 Roland Ave., Baltimore, Maryland 21211			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Sepsis</u> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 1 DAY
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Possible occult Abdominal carcinoma Anemia 2 to GI Bleeding							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Fredrick S. Kirk M.D.				29c. LICENSE NUMBER D22645		29d. DATE SIGNED (Month, Day, Year) 11/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FREDRICK S. KIRK M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222							
31. DATE FILED (Month, Day, Year) NOV 2 9 1995				32. REGISTRAR'S SIGNATURE J. A. [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6103

6103 25127

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Giovanni</i>				2. DATE OF DEATH MONTH <i>November</i> DAY <i>25</i> YEAR <i>1995</i>				3. TIME OF DEATH <i>8:44 A M</i>	
4. SOCIAL SECURITY NUMBER <i>216-20-7824</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>81</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Oct. 16, 1914</i>		8. BIRTHPLACE (State or Foreign Country) <i>Argentina</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Fallston General Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Fallston</i>				9c. COUNTY OF DEATH <i>Harford</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Harford</i>		10c. CITY, TOWN OR LOCATION <i>Fallston</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1805 Abelia Road</i>				10f. ZIP CODE <i>21047</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>3rd grade</i>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Steel Worker</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Steel Company</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Giovanni Marconi</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Maria Marconi</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Ada Marconi (wife)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1805 Abelia Rd., Fallston, MD 21047</i>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>Entombment</i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Lorraine Park Mausoleum</i>		DATE <i>11/28</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Matthew O'Connell</i>				22. NAME AND ADDRESS OF FACILITY <i>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Ventricular Fibrillation</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Diabetes Mellitus</i> DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval between Onset and Death <i>Ten minutes</i> <i>Ten years</i> <i>Ten years</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark P Wild MD</i>		29c. LICENSE NUMBER <i>d35522</i>		29d. DATE SIGNED (Month, Day, Year) <i>November 27, 1995</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Mark Wild 2 North Avenue Bel Air Maryland 21014</i>									
31. DATE FILED (Month, Day, Year) <i>NOV 29 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

95 36017

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James McNair				2. DATE OF DEATH MONTH November DAY 24 YEAR 1995		3. TIME OF DEATH 3:10A M	
4. SOCIAL SECURITY NUMBER 217-38-6696		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 4, 1943	
9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH n/a	
10a. STATE Maryland				10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 4608 Springdale Avenue			
10f. ZIP CODE 21207				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES May '65 May '68		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3+ College (1-4 or 5+) 3+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Mail Clerk		16b. KIND OF BUSINESS/INDUSTRY U.S. Postal Service			
17. FATHER'S NAME (First, Middle, Last) James Lee McNair				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gabrella Gore			
19a. INFORMANT'S NAME (Type/Print) Gabrella McNair				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4608 Springdale Avenue Baltimore, Maryland 21207			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD Veteran Cemetery/Garrison		20c. LOCATION — City or Town, State Nov 29 Owings Mills, Maryland		22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin Parker				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pancreatitis (Pancreatitis) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. Respiratory Failure b. Encephalopathy c. C d. C PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Terence L. Laha MD		29c. LICENSE NUMBER DR7203		29d. DATE SIGNED (Month, Day, Year) November 24 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Terence L. Laha Liberty Medical Center Baltimore, MD 21215							
31. DATE FILED (Month, Day, Year) NOV 29 1995		32. REGISTRAR'S SIGNATURE J. J. J. J.					

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

10
10A



95 36018

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANTONIO ENRIQUE MARRERO				2. DATE OF DEATH MONTH November DAY 22 , YEAR 1995		3. TIME OF DEATH 3:00 A M	
4. SOCIAL SECURITY NUMBER 584-42-2116		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 14, 1949	
8. BIRTHPLACE (State or Foreign Country) Puerto Rico		9a. FACILITY NAME (If not institution, give street and number) 495 Beltway and River Road		9b. CITY, TOWN OR LOCATION OF DEATH N/A		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 12 Sunnymead Ct.		10f. ZIP CODE 20845-2663		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES Vietnam		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: Puerto Rican		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Furniture			
17. FATHER'S NAME (First, Middle, Last) Miguel Marrero				18. MOTHER'S NAME (First, Middle, Maiden Surname) Estrella Biascochea			
19a. INFORMANT'S NAME (Type/Print) Graciela Marrero				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Sunnymead Ct., Rockville, MD 20845-2663			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Puerto Rico Memorial 11/25		20c. LOCATION — City or Town, State San Juan, PR			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leo W. [Signature]</i>				22. NAME AND ADDRESS OF FACILITY ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Head Injuries DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 11/22/95		28b. TIME OF INJURY unknown		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED Subject struck truck		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) roadway		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Interstate 495 between River Road and Old Georgetown Road in Bethesda, Maryland			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i>		29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) November 22, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 29 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36019

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth Angeline Meekins				2. DATE OF DEATH MONTH DAY YEAR Nov. 26 1995		3. TIME OF DEATH 5:50 P. M	
4. SOCIAL SECURITY NUMBER 213-09-5839		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 101 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 1, 1894	
9a. FACILITY NAME (If not institution, give street and number) Trinity Geriatric Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7600 Clays Lane				10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3rd Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Andrew Jackson Miller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Catherine Lang			
19a. INFORMANT'S NAME (Type/Print) Mr. Robert Meekins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9020 Dogwood Road Baltimore, MD 21207			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olive Church Cemetery 11/29		20c. LOCATION — City or Town, State Randallstown, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James B. Cooney</i>				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Heart Failure</i> <i>Chronic Obstructive Pulmonary Disease</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Raymond Miller MD</i>							
29c. LICENSE NUMBER D47683				29d. DATE SIGNED (Month, Day, Year) 11/28/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. RAYMOND MILLER, 7220 PARK HEIGHTS AVE. BALTO. MD 21208							
31. DATE SIGNED (Month, Day, Year) NOV 29 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36020

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Kenneth Patrick Mitchem				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 24 1995		3. TIME OF DEATH 7:47 P.M.	
4. SOCIAL SECURITY NUMBER 214-54-6903		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 45 YRS.	7. DATE OF BIRTH (Month, Day, Year) Jan. 27, 1950	8. BIRTHPLACE (State or Foreign Country) New York		
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore City		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 627 W. 36th Street				10f. ZIP CODE 21211		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sub Contractor		16b. KIND OF BUSINESS/INDUSTRY Messenger Service			
17. FATHER'S NAME (First, Middle, Last) Ivy Jack Mitchem				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa F. Sullivan			
19a. INFORMANT'S NAME (Type/Print) Mary Haines				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 W. 28th Street, Baltimore, Maryland 21211			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 11/27 Pikesville, Maryland		20c. LOCATION — City or Town, State		20d. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 21211 3631 Falls Road, Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Anoxic encephalopathy with deteriorating brainstem Approximate Interval Between Onset and Death: 7 hours							
b. Septic shock 4 DAYS							
c. METABOLIC ACIDOSIS (REFRACTORY) 2 DAYS							
d. Acute renal failure 4 DAYS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage AIDS							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER AT 2438946		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 24, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NEWY C. BAEZ, MD Union Memorial Hospital 201 E University Pkwy, Baltimore, MD 21218							
31. DATE FILED (Month, Day, Year) NOV 29 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

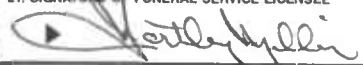


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36021

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CATHERINE P. NOELLERT				2. DATE OF DEATH MONTH DAY YEAR NOV 26, 1995		3. TIME OF DEATH 9:45 A. M.	
4. SOCIAL SECURITY NUMBER 18-46-5611		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT 05, 1900	
8a. FACILITY NAME (If not institution, give street and number) RESIDENCE) 4505 FOREST VIEW AVE				9b. CITY, TOWN OR LOCATION OF DEATH N/A		9c. COUNTY OF DEATH BALTIMORE MD.	
10a. STATE MD.				10b. COUNTY BALTIMORE MD.		10c. CITY, TOWN OR LOCATION N/A	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 4505 FOREST VIEW AVE BALTIMORE MD.			
10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? U S A			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH College (13-16 or 17+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOME MAKER		16b. KIND OF BUSINESS/INDUSTRY HOME	
17. FATHER'S NAME (First, Middle, Last) ANDREW WITTIG				18. MOTHER'S NAME (First, Middle, Maiden Surname) HELENE C. REIMER			
19a. INFORMANT'S NAME (Type/Print) WILLIAM NOELLERT JR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2701 SARAH LANE BALTIMORE MD. 21234			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OAK LAWN CEM.		20c. DATE 11/28		20d. LOCATION — City or Town, State BALTIMORE MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HARTLEY MILLER FUNERAL HOME 7527 HARFORD ROAD BALTIMORE MD. 21234			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Stroke DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  Attending				29c. LICENSE NUMBER D15408		29d. DATE SIGNED (Month, Day, Year) 11/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Denis MacDonald 9 South Highland Ave Balto Md 21224							
31. DATE FILED (Month, Day, Year) NOV 29 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36022

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ESTHER FARVER NAILL				2. DATE OF DEATH MONTH DAY YEAR November 24, 1995		3. TIME OF DEATH 7:35 PM	
4. SOCIAL SECURITY NUMBER 213-60-8726		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 9, 1901	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) Westminster Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll County	
10a. STATE Maryland				10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1234 Washington Rd.			
10f. ZIP CODE 21157				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 1 year		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Caregiver of Foster Children and Others		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) William Lee Farver				18. MOTHER'S NAME (First, Middle, Maiden Surname) Susan Jane Zile			
19a. INFORMANT'S NAME (Type/Print) Mr. Donald L. Naill				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 Ridge Rd. Westminster, MD 21157			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bethel Cemetery		20c. LOCATION — City or Town, State 11-27 New Windsor, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John K. Alesh</i>	
22. NAME AND ADDRESS OF FACILITY Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Vascular Insufficiency DUE TO (OR AS A CONSEQUENCE OF): Multiple Cerebral Infarctions DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David J. Walker M.D.</i>				29c. LICENSE NUMBER D 11496		29d. DATE SIGNED (Month, Day, Year) 11-24-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAVIER I. WELLIVER MD				31. DATE FILED (Month, Day, Year) NOV 29 1995			
32. REGISTRAR'S SIGNATURE <i>John K. Alesh</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36023

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) ELIZABETH OGBURN				2. DATE OF DEATH MONTH NOVEMBER DAY 27 YEAR 1995				3. TIME OF DEATH 0732 A M	
4. SOCIAL SECURITY NUMBER 220-05-9045		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-10-11		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON				9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEASED									
10a. STATE MD.		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 621 N. Woodington Road				10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress				16b. KIND OF BUSINESS/INDUSTRY Food	
17. FATHER'S NAME (First, Middle, Last) William East				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maryellen Turner					
19a. INFORMANT'S NAME (Type/Print) Roslyn Ogburn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4806 Edmondson Avenue Balto., MD. 21229					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of place, street, city or town, state, zip code) Western Cemetery 12/02/95				20c. LOCATION — City or Town, State Balto., MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dorothy Hester				22. NAME AND ADDRESS OF FACILITY 1721-27 N. Monroe St. E.L. Phillips F/H Balto., MD. 21217					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → FULMINANT HEPATIC FAILURE									
DUE TO (OR AS A CONSEQUENCE OF):									
END STAGE ALCOHOLIC CIRRHOSIS									
DUE TO (OR AS A CONSEQUENCE OF):									
MULTIPLE ORGAN FAILURE SYNDROME									
DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMA OF GALL BLADDER GANGRENOUS NECROTIZING CHOLECYSTITIS DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Riaz Bokhari M.D.				29c. LICENSE NUMBER D-26594				29d. DATE SIGNED (Month, Day, Year) 11/27/1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RIAZ BOKHARI M.D. 10 WARREN ROAD BALTIMORE MD 21030									
31. DATE FILED (Month, Day, Year) NOV 29 1995				32. REGISTRAR'S SIGNATURE J. H. Anderson-Rodell					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36024

Item 26, g-729, 11-29-95, per Dr., dk

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Kenneth Louis Orr Sr.				2. DATE OF DEATH MONTH DAY YEAR November 26, 1995		3. TIME OF DEATH 2:30a M	
4. SOCIAL SECURITY NUMBER 579-24-5827		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 20, 1908	
8a. FACILITY NAME (If not institution, give street and number) 3846 Muddy Creek Road				8b. CITY, TOWN OR LOCATION OF DEATH Edgewater		8c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Edgewater		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3846 Muddy Creek Road				10f. ZIP CODE 21037		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bus Driver		16b. KIND OF BUSINESS/INDUSTRY DC Tansit System			
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Peggy Svolos				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3846 Muddy Creek Road, Edgewater, MD 21037			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		DATE 11/29		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas A. Hardesty</i>				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pancreatic Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Anthony J. Calabrese</i>				29c. LICENSE NUMBER MD 23060		29d. DATE SIGNED (Month, Day, Year) 11/29/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANTHONY J. CALABRESE, M.D., 171 Defense Hwy Annapolis MD.							
31. DATE FILED (Month, Day, Year) NOV 29 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

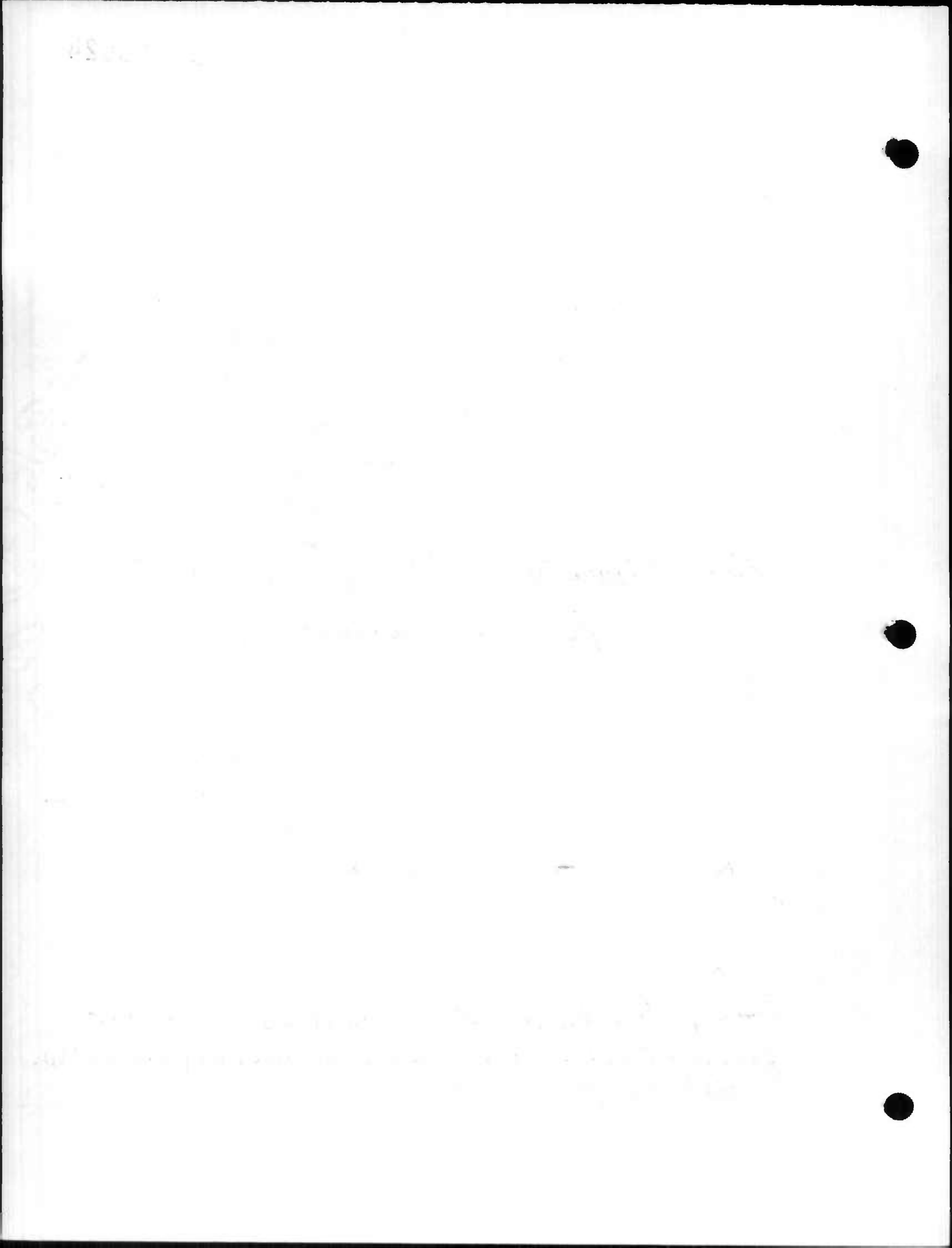
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1880



95 36025

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Veronica Agnes Phillips				2. DATE OF DEATH MONTH DAY YEAR Nov. 26 1995		3. TIME OF DEATH 3:45 P M	
4. SOCIAL SECURITY NUMBER 215-16-1835		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 30, 1904	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 4246 Nicholas Avenue			
10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Lady		16b. KIND OF BUSINESS/INDUSTRY Department Store			
17. FATHER'S NAME (First, Middle, Last) Joseph Matulewicz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva Papki			
19a. INFORMANT'S NAME (Type/Print) Richard G. Phillips (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1541 Sulphur Spring Rd., Baltimore, MD 21227			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Redeemer Cem. 11/30/95		20c. LOCATION — City or Town, State Baltimore, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert J. Siodak, Jr.	
22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Maryland 21213		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → WA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHF, COPD, CAD					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER A. J. IMPERIAL, Jr. MD				29c. LICENSE NUMBER 044505		29d. DATE SIGNED (Month, Day, Year) NOV 26, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. J. IMPERIAL, Jr. — St. Agnes Hosp.							
31. DATE FILED (Month, Day, Year) NOV 29 1995		32. REGISTRAR'S SIGNATURE John Anderson-Rodell					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36026

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Alice Protokowicz</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Nov. 28, 1995</i>		3. TIME OF DEATH <i>1:45 a. M</i>	
4. SOCIAL SECURITY NUMBER <i>222-09-3514</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>90</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>May 13, 1905</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Heart Heritage Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Street</i>		9c. COUNTY OF DEATH <i>Harford</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Harford</i>		10c. CITY, TOWN OR LOCATION <i>Joppa</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>717 Joppa Farm Road</i>				10f. ZIP CODE <i>21085</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Unknown</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Owner/Operator</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Tavern</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Stanley Lipinski</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Monica Kotowska</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Erma Protokowicz (Dghtr-in-law)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>717 Joppa Farm Road, Joppa, Md. 21085</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Sacred Heart of Jesus Cem. 12/2/95</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert J. Siodack, Jr.</i>				22. NAME AND ADDRESS OF FACILITY <i>Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>end-stage dementia</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia, COPD, CAD</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Heart Heritage</i>					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Alfred Sparks</i>				29c. LICENSE NUMBER <i>D28136</i>		29d. DATE SIGNED (Month, Day, Year) <i>11-28-95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. Alfred Sparks, 2105 Laurel Bush Road, Bel Air, Md. 21015</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 29 1995</i>				32. REGISTRAR'S SIGNATURE <i>Alfred Sparks</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ETHEL QUASNE

95 36027

Item 1, g-729, 11-29-95, perf. h., dk

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ethel Quasne QUASNE				2. DATE OF DEATH MONTH DAY YEAR NOV. 20 1995		3. TIME OF DEATH 8:27 A.M.	
4. SOCIAL SECURITY NUMBER 215-34-7514		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) February 20, 1910	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) Howard House Care Home		9b. CITY, TOWN OR LOCATION OF DEATH Taneytown		9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2222 Rockhaven Avenue				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 2+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cafeteria		16b. KIND OF BUSINESS/INDUSTRY Baltimore County School System			
17. FATHER'S NAME (First, Middle, Last) D.D. Howard Reck				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ina Celestine Conaway			
19a. INFORMANT'S NAME (Type/Print) Mary Quasne				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2222 Rockhaven Avenue Catonsville, Maryland 21228			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Good Shepherd Cemetery Nov. 29, 1995		20c. DATE Nov. 29, 1995		20d. LOCATION — City or Town, State Ellicott City, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>K. Clay Witzke</i>				22. NAME AND ADDRESS OF FACILITY Leroy M. & Russell C. Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland 21228			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. COMA DUE TO (OR AS A CONSEQUENCE OF): b. CEREBROVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 WKS 6 WKS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William R. Linthicum, M.D.</i>				29c. LICENSE NUMBER D14317		29d. DATE SIGNED (Month, Day, Year) 11/26/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM R. LINTHICUM, M.D. ONE KINGS DRIVE, TANEYTOWN, MD 21787							
31. DATE FILED (Month, Day, Year) NOV 29 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1951

RECEIVED

U.S. DEPT. OF AGRICULTURE

WASHINGTON, D.C.

RECEIVED

U.S. DEPT. OF AGRICULTURE

95 36028

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AGNES RAWA				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 27th 1995		3. TIME OF DEATH 7:05 P.M.	
4. SOCIAL SECURITY NUMBER 217-30-4448		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 13, 1907	
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 2231 Lake Avenue			
10f. ZIP CODE 21213				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Joseph Czernikowski				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Unknown			
19a. INFORMANT'S NAME (Type/Print) Bob Rawa (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1623 Druid Isle, Maitland, Florida 32751			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer Cem. 12/1/95		20c. LOCATION — City or Town, State Baltimore, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>	
22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, MD 21213		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) ISCHEMIC CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF): MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST CONGESTIVE HEART FAILURE RESPIRATORY FAILURE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.					
29c. LICENSE NUMBER P08236		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 27, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MAYA GUPTA GOOD SAMARITAN HOSPITAL							
31. DATE FILED (Month, Day, Year) NOV 29 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36029

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Charles Frank Stach</i>				2. DATE OF DEATH MONTH <i>11</i> DAY <i>26</i> YEAR <i>95</i>		3. TIME OF DEATH <i>2:16 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>216-12-2262</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>72</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>12/28/22</i>	
8. FACILITY NAME (If not institution, give street and number) <i>VA medical center / Baltimore</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>N/A</i>	
9a. RESIDENCE OF DECEDENT				10a. STATE <i>M.D.</i>		10b. COUNTY <i>N/A</i>	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>521 South Lakewood Avenue</i>				10f. ZIP CODE <i>21224</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WWII</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) <i>College</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Welder</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Bethlehem Steel</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Charles Frank Stach</i>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Marie Silt</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Shirley Stach (Wife)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>521 South Lakewood Ave., Baltimore, MD 21224</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Green Mount Crematory 11/28/95</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert Prodanoff</i>				22. NAME AND ADDRESS OF FACILITY <i>Schimunek Funeral Home 3331 Brehms Lane, Baltimore, MD 21213</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lung Cancer with metastasis</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Chronic Obstructive Lung disease</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>1:30PM</i> <i>~2:16PM</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Nahm, M.D.</i>				29c. LICENSE NUMBER <i>MR 7094</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/26/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John Nahm, M.D. House Officer VAMC Baltimore / M.D.</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 29 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Stach</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36030

Item#12. G-film 729 per FH 11/29/95 P.C

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James A. Sherman Sr.				2. DATE OF DEATH MONTH DAY YEAR Nov. 22, 1995		3. TIME OF DEATH 3:06 P M	
4. SOCIAL SECURITY NUMBER 214-24-2333		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 18, 1927	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 110 W. 27th Street				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machine Operator		16b. KIND OF BUSINESS/INDUSTRY Dairy Company			
17. FATHER'S NAME (First, Middle, Last) Ralph Sherman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mae Kiser			
19a. INFORMANT'S NAME (Type/Print) Wanda J. Sherman (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 W. 27th St., Baltimore, Maryland 21218			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens 11/27 Timonium, Maryland		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSER <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, MD 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): MYOCARDIAL INFARCTION b. DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE c. DUE TO (OR AS A CONSEQUENCE OF): d. DIABETES MELLITUS						Approximate Interval Between Onset and Death 3 months 12 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Miguel Karacuschansky M.D.</i>				29c. LICENSE NUMBER D15462		29d. DATE SIGNED (Month, Day, Year) 11/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MIGUEL KARACUSCHANSKY M.D. 300 E. 33rd ST BALTO. MD. 21218							
31. DATE FILED (Month, Day, Year) NOV 29 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION


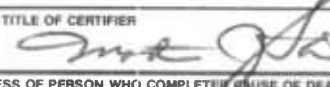
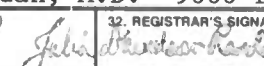
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68766
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item# 1.G-film 729 per F.H 11/29/95 P.C

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Harry William Sponheimer				2. DATE OF DEATH MONTH DAY YEAR November 22, 1995		3. TIME OF DEATH 11:35 p.m.	
4. SOCIAL SECURITY NUMBER 213-01-3859		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 9, 1914	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore County	
RESIDENCE OF DECEASED							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6912 Gunder Avenue				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY Steel Company			
17. FATHER'S NAME (First, Middle, Last) George Sponheimer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophie C. (surname unknown)			
19a. INFORMANT'S NAME (Type/Print) Thelma P. Sponheimer (wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6912 Gunder Ave., Baltimore, MD 21220			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery		DATE 11/27		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 3 days	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF):					
		c. Atrial Fibrillation, rapid ventricular response DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D21846		29d. DATE SIGNED (Month, Day, Year) November 24, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Martin Sheridan, M.D. 9000 Franklin Square Drive, Baltimore, Maryland 21237							
31. DATE FILED (Month, Day, Year) NOV 29 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36032

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Stratemeyer				2. DATE OF DEATH MONTH November DAY 27 YEAR 1995		3. TIME OF DEATH 10:30 p.m.	
4. SOCIAL SECURITY NUMBER 213-05-6087		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 15, 1918	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Bayview		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Md.		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 318 S. Robinson Street	
10f. ZIP CODE 21224				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY In own home	
17. FATHER'S NAME (First, Middle, Last) George Bauernfeind				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Jones			
19a. INFORMANT'S NAME (Type/Print) Thomas Stratemeyer, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5523 Lanham Way, Balto., Md. 21206			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart of Jesus 12/1		20c. LOCATION — City or Town, State Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Lilly & Zeiler Inc. 700 S. Conkling St. 21224			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Non small cell lung carcinoma							
DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 95012		29d. DATE SIGNED (Month, Day, Year) November 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Johns Hopkins Bayview Medical Center							
31. DATE FILED (Month, Day, Year) NOV 29 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36033

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BEVERLY C. SMITH				2. DATE OF DEATH MONTH DAY YEAR 11-20-1995		3. TIME OF DEATH 12:25p M	
4. SOCIAL SECURITY NUMBER 219-01-6373		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-30-1908	
9a. FACILITY NAME (If not institution, give street and number) MANOR CARE				9b. CITY, TOWN OR LOCATION OF DEATH RUXTON		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 600 DUNKIRK ROAD				10f. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 2YRS. SECRETARY		16b. KIND OF BUSINESS/INDUSTRY SECRETARY			
17. FATHER'S NAME (First, Middle, Last) NICHOLAS H. COCKEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) CORA POCKOCK			
19a. INFORMANT'S NAME (Type/Print) LAURA BECK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 MURDOCK RD. BALTO., MD. 21212.			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY 11/95		20c. LOCATION — City or Town, State BALTO., MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William R. Jenkins III</i>				22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>acute myocardial infarct</i> DUE TO (OR AS A CONSEQUENCE OF):					
		b. <i>arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Walter R. Welzant M.D.</i>				29c. LICENSE NUMBER P-12037		29d. DATE SIGNED (Month, Day, Year) 11/21/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WALTER R. WELZANT M.D. 7600 OSLER DR. TOWSON, MD, 21204.							
31. DATE FILED (Month, Day, Year) NOV 29 1995				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MELVIN TERRANCE STAPF, JR.				2. DATE OF DEATH MONTH November DAY 26 YEAR 1995		3. TIME OF DEATH 3:17 P M	
4. SOCIAL SECURITY NUMBER 214-44-0180		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 2, 1944	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Comfort Inn Truck Parking Lot		9b. CITY, TOWN OR LOCATION OF DEATH Perryville	
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 3104 Harview Ave.	
10f. ZIP CODE 21234				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Mechanic		16b. KIND OF BUSINESS/INDUSTRY Transportation	
17. FATHER'S NAME (First, Middle, Last) Melvin Terrance Stapf, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Conaway			
19a. INFORMANT'S NAME (Type/Print) Catherine E. Stapf				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3104 Harview Ave., Baltimore, MD 21234			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 11/28		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEAD INJURIES DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) PARKING LOT			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 11/26/95		28b. TIME OF INJURY 1505 PM	
28c. INJURY AT WORK? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED TIRE EXPLODED WHILE CHANGING TIRE		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) PARKING LOT	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMFORT INN TRUCK PARKING LOT				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) NOV. 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLUS JR MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED NOV 8, 9 1995				32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 36035

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES R. SCOTT				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 22, 1995				3. TIME OF DEATH 8:50 a m	
4. SOCIAL SECURITY NUMBER 217-24-8632		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUL 27, 1928		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Halethorpe				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5657 Selford Rd.				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dye Maker		16b. KIND OF BUSINESS/INDUSTRY Dixie Paper Box					
17. FATHER'S NAME (First, Middle, Last) Charles A. Scott				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice C. Shifflett					
19a. INFORMANT'S NAME (Type/Print) Geraldine E. Scott				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5657 Selford Rd., Halethorpe, Md. 21227					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Good Shepherd Cem., Inc. 11/27		20c. LOCATION — City or Town, State Howard Co., Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 DAY YEARS								Approximate Interval Between Onset and Death 1 DAY YEARS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Patrick A. DeValeria, MD				29c. LICENSE NUMBER D 40218		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 22, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Patrick A. DeValeria MD 600 N. Wolfe Street; Block 618; Baltimore MD 21287									
31. DATE OF DEATH NOV 22 1995				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEM: 18. PER F.H. FILM G-730 12/4/95 t.t
Item 4, g-729, 11-29-95, perf. h., dk

95 36036

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT WAYNE SPROUSE		2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 23, 1995		3. TIME OF DEATH 0405A M	
4. SOCIAL SECURITY NUMBER 217 217 217		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 01 21 59		8. BIRTHPLACE (State or Foreign Country) Maryland		9. COUNTY OF DEATH N/A	
9a. FACILITY NAME (If not institution, give street and number) 405 SOUTH NEWKIRK STREET		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
10a. STATE Md.		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 405 S. Newkirk Street		10f. ZIP CODE 21224	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Construction		17. FATHER'S NAME (First, Middle, Last) Harry Porter Sprouse Sr.	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Mary Sprouse, Sr. MOROSCHOK		19a. INFORMANT'S NAME (Type/Print) Bertha M. Sprouse		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 S. Newkirk Street Baltimore, Md. 21224	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 11-28-95		20c. LOCATION — City or Town, State Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler		22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 6224 Eastern Ave. Balto., Md.		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONTACT GUNSHOT WOUND OF HEAD DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO HOD ONLY		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		27. DATE OF INJURY (Month, Day, Year) 11 23 95		28. TIME OF INJURY FOUND A M	
29. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home		29a. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		29b. DESCRIBE NOW INJURY OCCURRED SHOTS TO STOMACH	
29c. LOCATION (Street and Number or Rural Route Number, City or Town, State) 405 S. NEWKIRK BALTIMORE MD		29d. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29e. SIGNATURE AND TITLE OF CERTIFIER Marie D. [Signature]	
29f. LICENSE NUMBER O.C.M.E.		29g. DATE SIGNED (Month, Day, Year) NOVEMBER 23, 1995		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYDAIS A. MOROSCHOK 111 Penn Street, Baltimore, Maryland 21201	
31. DATE FILED (Month, Day, Year) NOV 29 1995		32. REGISTRAR'S SIGNATURE [Signature]		33. [Blank]	

DIVISION OF VITAL RECORDS, P.O. BOX 6876
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

95 36037

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CORVANDELLA D THOMAS				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 27 1995		3. TIME OF DEATH 13 27 PM	
4. SOCIAL SECURITY NUMBER 214-90-0006		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 33 YRS.	7. DATE OF BIRTH (Month, Day, Year) OCT. 6, 1962		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 234 S. MT. OLIVET LANE				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SUPERVISOR		16b. KIND OF BUSINESS/INDUSTRY LAUNDRY			
17. FATHER'S NAME (First, Middle, Last) ODELL HARRISON				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY CHAPLIN			
19a. INFORMANT'S NAME (Type/Print) MARY CHAPLIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 234 S. MT. OLIVET LANE BALTIMORE, MD. 21229			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION		20c. LOCATION — City or Town, State 12/2/95 LAUSDORF MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY GARY P. MARCH FUNERAL HOME P.A. 270 FRED HILTON PASS BALTIMORE, MD. 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. BREAST CARCINOMA					Approximate Interval Between Onset and Death 1 1/2 years
		b. METASTASIS TO BONE AND LUNG					1 1/2 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D 38543		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 27, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KEVIN H. SCRUGGS MD 900 CARON AVENUE BALTIMORE, MARYLAND 21229							
31. DATE FILED (Month, Day, Year) NOV 8, 9 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 36038

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Howard N. Vaughn				2. DATE OF DEATH MONTH DAY YEAR November 22, 1995				3. TIME OF DEATH 2:20 P.M.					
4. SOCIAL SECURITY NUMBER 235-30-7167		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Nov 6, 1923		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) 5465 Bucknell Road						9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH n/a			
RESIDENCE OF DECEDENT													
10a. STATE Maryland				10b. COUNTY n/a				10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5465 Bucknell Road						10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Military Service Man				16b. KIND OF BUSINESS/INDUSTRY U.S. Government					
17. FATHER'S NAME (First, Middle, Last) Charles Vaughn						18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Toney							
19a. INFORMANT'S NAME (Type/Print) Alfred Vaughn						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5465 Bucknell Road Baltimore, Maryland 21206							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD Veteran Cemetery/Garrison NOV 28				20c. LOCATION — City or Town, State Owings Mills, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Herbert E. Nutter						22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →				a. Lung Cancer with Brain Metastases DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				b. DUE TO (OR AS A CONSEQUENCE OF):									
				c. DUE TO (OR AS A CONSEQUENCE OF):									
				d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Mohamed Al-Ibrahim, M.D.						29c. LICENSE NUMBER D15450				29d. DATE SIGNED (Month, Day, Year) 11-27-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mohamed Al-Ibrahim, M.D., 10 N. Greene St., Baltimore, MD 21201													
31. DATE WHEN MADE NOV 29 1995													

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36039

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Michael Wojatszek				2. DATE OF DEATH MONTH DAY YEAR Nov. 20, 1995		3. TIME OF DEATH 10:30a M	
4. SOCIAL SECURITY NUMBER 212-32-3511		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 1, 1899	
8. BIRTHPLACE (State or Foreign Country) Ukraine				9a. FACILITY NAME (If not institution, give street and number) Bay Meadows Nursing & Rehab Center		9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Glen Burnie				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 7355 Furnace Branch Road	
10f. ZIP CODE 21061				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer		16b. KIND OF BUSINESS/INDUSTRY Farming			
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Fr. Dornik				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 S. Ann Street, Baltimore, Md. 21231			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Michael Ukrainian Cem 11/25		20c. LOCATION — City or Town, State Baltimore, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Elizabeth A. Salinski	
22. NAME AND ADDRESS OF FACILITY Lilly & Zeiler, Inc. Funeral Homes 1901 Eastern Ave. Balto., MD 21231		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Underlying Cause: Pneumonia PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Dementia DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER D27569		29d. DATE SIGNED (Month, Day, Year) 11/22/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Allen Settleman 1777 Reisterstown Rd #365							
31. DATE FILED (Month, Day, Year) NOV 29 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36040

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Leroy Williams				2. DATE OF DEATH MONTH DAY YEAR November 20th 1995		3. TIME OF DEATH 1:10 a M	
4. SOCIAL SECURITY NUMBER 220-03-8708		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 28, 1914	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH n/a			
9a. FACILITY NAME (If not institution, give street and number) Bon Secour Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH n/a	
10a. STATE Maryland		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2427 West Lexington Street				10f. ZIP CODE 21223		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Shipping Clerk		16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel Corporation			
17. FATHER'S NAME (First, Middle, Last) Henry Williams				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marguerite Brooks			
19a. INFORMANT'S NAME (Type/Print) Estelle Williams				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2427 West Lexington Street Baltimore, MD 21223			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		DATE Nov22		20c. LOCATION — City or Town, State Catonsville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gary L. Follen				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. CerebroVascular Accident b. Diabetes Mellitus c. Bilateral Carotid Artery occlusive disease d. 11 days						Approximate Interval Between Onset and Death 11 days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 8 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Kerran Elder MD House officer				29c. LICENSE NUMBER 038993		29d. DATE SIGNED (Month, Day, Year) 11/20/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kerran Elder 2600 Liberty Hgts Baltimore Maryland 21215							
31. DATE FILED (Month, Day, Year) NOV 29 1995				32. REGISTRAR'S SIGNATURE Julia Anderson-Russell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THELMA IDA WOLLENWEBER				2. DATE OF DEATH MONTH November DAY 27 YEAR 1995		3. TIME OF DEATH 11:39 P M	
4. SOCIAL SECURITY NUMBER 219-32-1158D		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 1, 1901	
9a. FACILITY NAME (If not institution, give street and number) Wesley Home				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3018 Fleetwood Ave.				10f. ZIP CODE 21214		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Operator		16b. KIND OF BUSINESS/INDUSTRY Telephone Co.	
17. FATHER'S NAME (First, Middle, Last) Harry C. Davis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Mae Horstman			
19a. INFORMANT'S NAME (Type/Print) Charles H. Wollenweber, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1216 Bonaire Rd., Forest Hill, MD 21050			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. LOCATION — City or Town, State 11/30 Baltimore, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Goye</i>				22. NAME AND ADDRESS OF FACILITY ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Disease. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Heart Failure							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Goye, M.D.</i>				29c. LICENSE NUMBER 21214		29d. DATE SIGNED (Month, Day, Year) 11/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3508 BANK ST BALTO, Md 21224							
31. DATE FILED (Month, Day, Year) NOV 29 1995				32. REGISTRAR'S SIGNATURE <i>John H. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

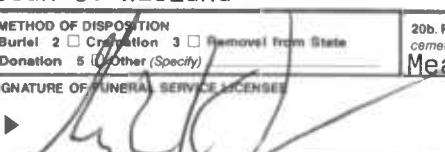


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36042

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FREDERICK C. WIELAND, SR.				2. DATE OF DEATH MONTH DAY YEAR NOV 24 1995		3. TIME OF DEATH 4:15 PM		
4. SOCIAL SECURITY NUMBER 213-28-1977		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEP. 28, 1931		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) University Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A		
RESIDENCE OF DECEDENT								
10a. STATE Md.		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Jessup		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 1919 Hilltop Rd.				10f. ZIP CODE 20794		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Crane Operator		16b. KIND OF BUSINESS/INDUSTRY Kaiser Aluminum				
17. FATHER'S NAME (First, Middle, Last) Walter C. Wieland				16. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy B. Campbell				
19a. INFORMANT'S NAME (Type/Print) Joan C. Wieland				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1919 Hilltop Rd., Jessup, Md. 20794				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park		DATE 11/28		20c. LOCATION — City or Town, State Elkridge, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE MYOCARDIAL INFARCTION Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							Approximate Interval Between Onset and Death 24 hrs	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28e. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER  M.D.				29c. LICENSE NUMBER PO 8630		29d. DATE SIGNED (Month, Day, Year) NOV 24 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MANSUR G. SHOMALI, M.D. 22S GREENE ST BALTIMORE, MD #21201								
31. DATE FILED (Month, Day, Year) NOV 29 1995		32. REGISTRAR'S SIGNATURE 						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

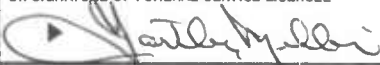


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36043

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNE M. WILSON				2. DATE OF DEATH MONTH NOV DAY 25 YEAR 1995		3. TIME OF DEATH 2:30 PM	
4. SOCIAL SECURITY NUMBER 213-20-9531		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 13, 1925	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE MARYLAND	
9c. COUNTY OF DEATH N/A				10a. STATE MD.			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION BALTIMORE MARYLAND			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 4406 ANNTANA AVE			
10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK		16b. KIND OF BUSINESS/INDUSTRY STATE OF MARYLAND	
17. FATHER'S NAME (First, Middle, Last) THOMAS WRIGHTSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) PAULIAX MURRAY			
19a. INFORMANT'S NAME (Type/Print) KATHY WILSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4406 ANNTANA AVE BALTIMORE MD. 21206			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MORELAND MEM CEM		DATE 11/28		20c. LOCATION — City or Town, State BALTIMORE MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HARTLEY MILLER FUNERAL HOME 7527 HARFORD ROAD BALTIMORE MARYLAND 21234			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION							
DUE TO (OR AS A CONSEQUENCE OF):							
b. CORONARY ARTERY DISEASE							
DUE TO (OR AS A CONSEQUENCE OF):							
c. _____							
DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER  H. Anderson M.D.				29c. LICENSE NUMBER P-06-064		29d. DATE SIGNED (Month, Day, Year) NOV 25, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HAZEM AL-ANDARY. GOOD SAM. HOSP. OF MARYLAND INC.							
31. DATE FILED (Month, Day, Year) NOV 29 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36044

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Willie Mae Anderson				2. DATE OF DEATH MONTH November DAY 10 YEAR 1995				3. TIME OF DEATH 01:05 A.M.	
4. SOCIAL SECURITY NUMBER 434-30-8307		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7. DATE OF BIRTH (Month, Day, Year) Feb 18, 1906				8. BIRTHPLACE (State or Foreign Country) Louisiana					
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hosp.				9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Germantown				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 18222 Smokehouse Ct,				10f. ZIP CODE 20874		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY None	
17. FATHER'S NAME (First, Middle, Last) Unk.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Allen					
19a. INFORMANT'S NAME (Type/Print) (Son) Mr Jimmy Anderson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22193 6111 Plainville La, Woodbridge, Va.					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate Of Heaven Cem. 11/18				20c. LOCATION — City or Town, State Silver Spring, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Anderson</i>				22. NAME AND ADDRESS OF FACILITY Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Md					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → urosepsis Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST pneumonia DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death days days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Abulfarag, MD</i>				29c. LICENSE NUMBER 31391 D				29d. DATE SIGNED (Month, Day, Year) November 10, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Suhair Abulfarag, MD 481 N. Frederick ave. Suite 203 - Gaithersburg, MD 20877									
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6 95 36045

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SARAH MAE ALLEN				2. DATE OF DEATH MONTH DAY YEAR Nov. 5, 1995		3. TIME OF DEATH 4:30 A	
4. SOCIAL SECURITY NUMBER 214-26-3485		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/3/30	
9a. FACILITY NAME (If not institution, give street and number) 3162 Tucker Drive				9b. CITY, TOWN OR LOCATION OF DEATH Street		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Street		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3162 Tucker Road				10f. ZIP CODE 21154		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) Homemaker		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		18b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Alvin Alfred Ford				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Mae Creswell			
19a. INFORMANT'S NAME (Type/Print) James L. Allen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3162 Tucker Rd., Street, MD 21154			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dublin Southern Cem. 11/8/95		20c. LOCATION — City or Town, State Street, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John B. Tillet</i>				22. NAME AND ADDRESS OF FACILITY Harkins F.H. Inc., Delta, PA 17314			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Aspiration and respiratory arrest					Approximate Interval Between Onset and Death a week
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Bronchogenic carcinoma					10 mths
		c. Cerebrovascular accident with dysphagia					Few years
		d. Ventriculo peritoneal shunt and cerebral hemorrhage					Few years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus / coronary artery disease / Peripheral vascular disease / Decubitus ulcers							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO NA	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) NA		28b. TIME OF INJURY NA M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED NA		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) NA	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Muthulaksami</i> MD C MUTHULAKSAMI RAMESH				29c. LICENSE NUMBER D 44248		29d. DATE SIGNED (Month, Day, Year) Nov. 6, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Meera Matthews, M.D., 104 Plumtree Rd., Bel Air, MD							
31. DATE FILED (Month, Day, Year) NOV 8 1995				32. REGISTRAR'S SIGNATURE <i>John A. Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

27

1944



95 36046

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dorothy AGNES Anderson				2. DATE OF DEATH MONTH DAY YEAR NOV. 7 95		3. TIME OF DEATH 7:18 P M	
4. SOCIAL SECURITY NUMBER 062-12-8630		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/20/1920	
8. BIRTHPLACE (State or Foreign Country) Canada				9a. FACILITY NAME (If not institution, give street and number) Bel Air Convalescent Center		9b. CITY, TOWN OR LOCATION OF DEATH Bel Air	
9c. COUNTY OF DEATH Harford				10a. STATE Maryland		10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Bel Air				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2004 Helton Avenue	
10f. ZIP CODE 21015				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse		16b. KIND OF BUSINESS/INDUSTRY Nursing	
17. FATHER'S NAME (First, Middle, Last) Joseph Henry Hawes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Agnes Stewart			
19a. INFORMANT'S NAME (Type/Print) Dorothy N. Rattigan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1695 Kenneth Rd. York, Pa. 17404			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cemetery 11/11		20c. LOCATION — City or Town, State Bel Air, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. Blodgett Ruffin				22. NAME AND ADDRESS OF FACILITY Kurtz Funeral Home Jarrettsville, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Encephalopathy DUE TO (OR AS A CONSEQUENCE OF): b. Partial-Complex Seizures DUE TO (OR AS A CONSEQUENCE OF): c. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): d. Chronic Atrial Fibrillation Approximate Interval Between Onset and Death 3 weeks 2 years 5 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER A. Howard MD				29c. LICENSE NUMBER D34652		29d. DATE SIGNED (Month, Day, Year) November 8, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Scott Haswell 2 North Ave Bel Air Maryland 21014							
31. DATE FILED (Month, Day, Year) NOV 14 1995				32. REGISTRAR'S SIGNATURE J. Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36047

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Eva S. Adams</i>				2. DATE OF DEATH MONTH <i>November</i> DAY <i>12</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>5:45 A M</i>	
4. SOCIAL SECURITY NUMBER <i>579-03-6184</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>86</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>NOV. 26, 1908</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>NATIONAL LUTHERAN HOME</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>ROCKVILLE</i>		9c. COUNTY OF DEATH <i>MONTGOMERY CO.</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MD.</i>		10b. COUNTY <i>MONTGOMERY CO.</i>		10c. CITY, TOWN OR LOCATION <i>BETHESDA</i>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>6530- DEMOCRACY BLVD.</i>				10f. ZIP CODE <i>20817</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOMEMAKER</i>		16b. KIND OF BUSINESS/INDUSTRY <i>AT HOME</i>			
17. FATHER'S NAME (First, Middle, Last) <i>GEORGE J. STIEMLY</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>LAURA PASQUAY</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MS. ROSE KOERBER</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>18703-WALKER'S CHOICE RD., GAITHERSBURG, MD.</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>PARKWOOD CEMETERY</i>		DATE <i>11/16</i>		20c. LOCATION — City or Town, State <i>BALTIMORE, MD.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. M. Hyson</i>				22. NAME AND ADDRESS OF FACILITY <i>HYSONG CO., INC. 1300- N ST., NW, WASH., DC</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<i>respiratory insufficiency</i>				Approximate Interval Between Onset and Death <i>1 hr.</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		DUE TO (OR AS A CONSEQUENCE OF):				unknown	
		<i>renal insufficiency</i>					
		DUE TO (OR AS A CONSEQUENCE OF):				10 years	
		<i>cerebrovascular disease</i>					
		DUE TO (OR AS A CONSEQUENCE OF):				over 10 years	
		<i>atherosclerosis</i>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles W. Kreshins</i>		29c. LICENSE NUMBER <i>Q21726</i>		29d. DATE SIGNED (Month, Day, Year) <i>November 13 95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>9701 Wiers Drive, Rockville, Maryland</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 17 1995</i>		32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Theodore ALLEN</u>				2. DATE OF DEATH MONTH <u>November</u> DAY <u>8</u> YEAR <u>1995</u>				3. TIME OF DEATH <u>4:10P</u> M	
4. SOCIAL SECURITY NUMBER <u>249-03-3881</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>80</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) <u>DECEMBER 16, 1914</u>				8. BIRTHPLACE (State or Foreign Country) <u>South Carolina</u>					
9a. FACILITY NAME (If not institution, give street and number) <u>HOLY CROSS HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>LAMHAM</u>				9c. COUNTY OF DEATH <u>PRINCE GEORGE'S</u>	
10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>PRINCE GEORGE'S</u>		10c. CITY, TOWN OR LOCATION <u>FORESTVILLE</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>6525 HIL-MAR DRIVE</u>				10f. ZIP CODE <u>20747</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>TAXI CAB DRIVER</u>				16b. KIND OF BUSINESS/INDUSTRY <u>PRIVATE</u>			
17. FATHER'S NAME (First, Middle, Last) <u>GEORGE ALLEN</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>LESLIE (NOT AVAILABLE)</u>					
19a. INFORMANT'S NAME (Type/Print) <u>DOROTHY MAE ALLEN (WIFE)</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6525 HIL-MAR DRIVE; FORESTVILLE, MARYLAND 20747</u>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>FT. LINCOLN CEMETERY 11/14/95</u>				20c. LOCATION — City or Town, State <u>BLA BRENTWOOD, MD.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Glenda M. Freeman</u>				22. NAME AND ADDRESS OF FACILITY <u>JOHNSON & JENKINS FUNERAL HOME, INC. 716 KENNEDY STREET, N.W.; WDC 20011</u>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Advanced Cancer of Prostate</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <u>Years</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dr. Jalal Fatemi</u>				29c. LICENSE NUMBER <u>D15214</u>				29d. DATE SIGNED (Month, Day, Year) <u>11.9.95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Dr. Jalal Fatemi 1328 Southern Avenue, SE Washington, DC 20032</u>									
31. DATE FILED (Month, Day, Year) <u>NOV 13 1995</u>				32. REGISTRAR'S SIGNATURE <u>Jalal A. H. H. H.</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

7

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36049

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Myrtle H. Berrett				2. DATE OF DEATH MONTH DAY YEAR November 12, 1995		3. TIME OF DEATH 9:45A. M	
4. SOCIAL SECURITY NUMBER 213-09-8139		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 97 YRS.	7. DATE OF BIRTH (Month, Day, Year) June 20, 1898		8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) 4500 Samar Street				9b. CITY, TOWN OR LOCATION OF DEATH Beltsville		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Beltsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4500 Samar Street				10f. ZIP CODE 20705		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 6 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Domestic			
17. FATHER'S NAME (First, Middle, Last) Archibald Blackburn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Jane Brock			
19a. INFORMANT'S NAME (Type/Print) Grace I. Elmo				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 11/15/95		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald V. Borgwardt				22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Metastatic Cancer of Lungs and Liver 3 months					
		b. Due TO (OR AS A CONSEQUENCE OF): Coronary Heart Failure 3 years					
		c. Due TO (OR AS A CONSEQUENCE OF):					
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Nomicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]		29c. LICENSE NUMBER D13339		29d. DATE SIGNED (Month, Day, Year) November 13, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Tsanie Chanchien, M.D. 8824 Cunningham Dr. Berwyn Heights, Md. 20740							
31. DATE FILED (Month, Day, Year) NOV 17 1995		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36050

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Armenak Boghozian				2. DATE OF DEATH MONTH DAY YEAR November 9, 1995				3. TIME OF DEATH 17:09 M	
4. SOCIAL SECURITY NUMBER 214-19-2652		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) Feb. 14, 1913				8. BIRTHPLACE (State or Foreign Country) Iran					
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Germantown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 19509 Gunners Branch Road Apartment A				10f. ZIP CODE 20876				10g. CITIZEN OF WHAT COUNTRY? Iran	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver				16b. KIND OF BUSINESS/INDUSTRY Transportation Industry	
17. FATHER'S NAME (First, Middle, Last) Hakop Boghozian				18. MOTHER'S NAME (First, Middle, Maiden Surname) Tuti UNKNOWN					
19a. INFORMANT'S NAME (Type/Print) Linda Boghosian				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19509 Gunners Branch Rd., Apt. A, Germantown, MD 20876					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Norbeck Memorial Park 11/14				20c. LOCATION — City or Town, State Olney, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY De Vol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPTICEMIA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 24 Hrs.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D26540	
				29d. DATE SIGNED (Month, Day, Year) Nov 9 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carli Schenberger 16220 Frederick Rd. Gaithersburg									
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36051

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth C. Bailey				2. DATE OF DEATH MONTH DAY YEAR November 14, 1995		3. TIME OF DEATH 1:20 P M		
4. SOCIAL SECURITY NUMBER 578-52-8237		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 103 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 8, 1892		
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Waldorf Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH Waldorf		
9c. COUNTY OF DEATH Charles				10a. STATE Maryland		10b. COUNTY Montgomery		
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3701 International Drive		
10f. ZIP CODE 20906				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Examiner of Money		16b. KIND OF BUSINESS/INDUSTRY Bureau of Engraving		
17. FATHER'S NAME (First, Middle, Last) Alfred A. Penn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary L. Wedding				
19a. INFORMANT'S NAME (Type/Print) Ruby Haney				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3417 Saint Leonards Court, Silver Spring, Maryland 20906				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Port Lincoln Cemetery 11/18		20c. LOCATION — City or Town, State Brentwood, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Ruptured Aortic Aneurysm</u> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>Atherosclerosis</u> c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							Approximate interval Between Onset and Death	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER M.D.				29c. LICENSE NUMBER D29646		29d. DATE SIGNED (Month, Day, Year) 11-14-95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joel Sewchand, M.D. 118 LaGrange Avenue, LaPlata, Maryland 20646								
31. DATE FILED (Month, Day, Year) NOV 16 1995				32. REGISTRAR'S SIGNATURE 				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36052

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GORDON ROBERT BROWN				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 11 1995		3. TIME OF DEATH 2:40 P M	
4. SOCIAL SECURITY NUMBER 114-42-0974		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 42 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAR 6 1953	
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MAINE		10b. COUNTY CUMBERLAND		10c. CITY, TOWN OR LOCATION BRUNSWICK		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 20 OAKWOOD TERRACE				10f. ZIP CODE 04011		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1972 - 1995		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) U S NAVY		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DEFENSE		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) WILBUR FRED BROWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) KARLYN STURGIS			
19a. INFORMANT'S NAME (Type/Print) BARBARA J. BROWN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 OAKWOOD TERRACE, BRUNSWICK ME 04011			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CALVERTON CEMETERY 11/17		20c. LOCATION — City or Town, State LONG ISLAND, N.Y.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0091				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTI-ORGAN SYSTEM FAILURE DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. LIVER FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 2 weeks MONTHS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  BROOKS D. CASH, MD					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BROOKS D. CASH, MD		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LT. MC USN NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20889-5000					
31. DATE FILED (Month, Day, Year) NOV 16 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

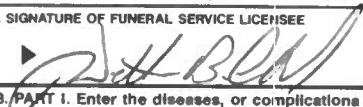

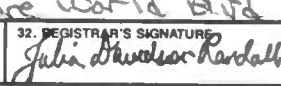
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY F. BARNES				2. DATE OF DEATH MONTH NOV. DAY 10, YEAR 1995		3. TIME OF DEATH 4:15 P M	
4. SOCIAL SECURITY NUMBER 480-03-2045		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 28, 1912	
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Olney		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 15301 Pine Orchard Drive			
10f. ZIP CODE 20906				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Statistician		16b. KIND OF BUSINESS/INDUSTRY Reinsurance Company			
17. FATHER'S NAME (First, Middle, Last) Earl W. Fernow				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace D. Clements			
19a. INFORMANT'S NAME (Type/Print) Byron A. Barnes (Husband)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory 11-11		20c. LOCATION — City or Town, State Beltsville, MD		20d. DATE 11-11	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intracerebral bleed DUE TO (OR AS A CONSEQUENCE OF): b. HTN DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 3 days Years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D43202		29d. DATE SIGNED (Month, Day, Year) November 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. O. Zanne - Blankland MD 3305 N. Leisure World Blvd Silver Spring, MD 20906							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT M. BROOKS				2. DATE OF DEATH MONTH 11 DAY 11 YEAR 95		3. TIME OF DEATH 4 AM M	
4. SOCIAL SECURITY NUMBER 579-72-7976		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 42 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 4, 1953	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) HYATTSVILLE MANOR		9b. CITY, TOWN OR LOCATION OF DEATH HYATTSVILLE	
9c. COUNTY OF DEATH PG				10a. STATE MD		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Hyattsville				10d. INSIDE CITY LIMITS? 1 YES 2 NO		10e. STREET AND NUMBER 6500 Riggs Road	
10f. ZIP CODE 20783				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: Black				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance Worker				16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) Robert Brooks				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mamie Ruth Oliver			
19a. INFORMANT'S NAME (Type/Print) Arlene Lujeania Isom (Aunt)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2806 Kingsway Rd, Ft. Washington, MD 20744			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Chesapeake Crematory 11-12			
20c. LOCATION — City or Town, State Beltsville, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] M00827			
22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST required in massive defibrillation syndrome			
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 7 Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]			
29c. LICENSE NUMBER DO1494				29d. DATE SIGNED (Month, Day, Year) Nov. 11, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lewis H. Dennis, M.D. 6201 Greenbelt Rd #U-1, College Park, MD 20740-2356							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Wilbur BROWER</u>				2. DATE OF DEATH MONTH DAY YEAR <u>November 8, 1995</u>		3. TIME OF DEATH <u>3:30P</u> M	
4. SOCIAL SECURITY NUMBER <u>238-10-9322</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>78</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>AUG. 22, 1917</u>	
8a. FACILITY NAME (If not institution, give street and number) <u>DOCTORS HOSPITAL</u>				8b. CITY, TOWN OR LOCATION OF DEATH <u>LANHAM</u>		8c. BIRTHPLACE (State or Foreign Country) <u>N. CAROLINA</u>	
9. RESIDENCE OF DECEDENT				10a. STATE <u>MD.</u>		10b. COUNTY <u>PRINCE GEORGES</u>	
10c. CITY, TOWN OR LOCATION <u>COLLEGE PARK</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>5121 NAVAHOE ST.</u>	
10f. ZIP CODE <u>20740</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>MAINTENANCE</u>		16b. KIND OF BUSINESS/INDUSTRY <u>NCHA</u>	
17. FATHER'S NAME (First, Middle, Last) <u>WESLEY BROWER</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>NANNIE HARRINGTON</u>			
19a. INFORMANT'S NAME (Type/Print) <u>CLARA CARVER</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5807 NICHOLSON ST., RIVERDALE, MD. 20737</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>MARYLAND NATIONAL CEM. 11/13</u>		20c. LOCATION — City or Town, State <u>LAUREL, MD.</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>W.W. Chambers</u> M00091				22. NAME AND ADDRESS OF FACILITY <u>W. W. CHAMBERS CO., RIVERDALE, MD. 20737</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac arrest</u>							
b. <u>Massive Gastric Hemorrhage</u>							
c. <u>Gastric cancer with liver metastasis</u>							
d. <u></u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Abdominal Aorta Aneurysm, dissecting</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <u></u>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Tungpi Lee M.D.</u>				29c. LICENSE NUMBER <u>D26707</u>		29d. DATE SIGNED (Month, Day, Year) <u>11-9-95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>TUNGPI LEE M.D. 700 Buckingham Dr. Silver Spring MD 20901</u>							
31. DATE FILED (Month, Day, Year) <u>NOV 13 1995</u>				32. REGISTRAR'S SIGNATURE <u>John Andrew Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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95 36056

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILDRED E. BROWN				2. DATE OF DEATH MONTH DAY YEAR NOV. 7, 1995		3. TIME OF DEATH 11:25 A M	
4. SOCIAL SECURITY NUMBER 214.48.7537		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 23, 1902	
8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA				9a. FACILITY NAME (If not institution, give street and number) 4319 HARRISON STREET N.W.		9b. CITY, TOWN OR LOCATION OF DEATH WASHINGTON DC	
9c. COUNTY OF DEATH				10a. STATE			
10b. COUNTY				10c. CITY, TOWN OR LOCATION WASHINGTON DC			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 4319 HARRISON STREET N.W.			
10f. ZIP CODE 20016				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOMEMAKER				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWN HOME		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) EDWARD KESTER				18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARA GRABER			
19a. INFORMANT'S NAME (Type/Print) ELDON BROWN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5006 ADRIAN STREET ROCKVILLE, MD. 20853			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) PARKLAWN MEM. PARK 11/9		20c. LOCATION — City or Town, State ROCKVILLE, MD.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kenneth Simmons</i>	
22. NAME AND ADDRESS OF FACILITY JOS GAWLERS SONS INC. 5130 WI AVE NW WASHINGTON, D.C. 20016				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → cardiac arrest DUE TO (OR AS A CONSEQUENCE OF): a. atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): b. chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): c. cigarette smoking DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cigarette smoking				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stuart Ross</i>				29c. LICENSE NUMBER 016819		29d. DATE SIGNED (Month, Day, Year) NOV. 7, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STUART ROSS M.D. 5100 WISC. AVE NW WASHINGTON, D.C. 20016							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

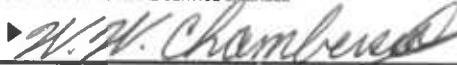

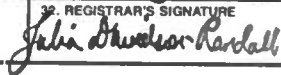
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36057

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MICHAEL SCOTT BOYER				2. DATE OF DEATH MONTH NOVEMBER DAY 8 YEAR 1995				3. TIME OF DEATH 9:30 a.m.		
4. SOCIAL SECURITY NUMBER 223-80-4902		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 42 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 		
7. DATE OF BIRTH (Month, Day, Year) MARCH 31, 1953				8. BIRTHPLACE (State or Foreign Country) CALIFORNIA						
9a. FACILITY NAME (If not institution, give street and number) N.I.H. CLINICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA				9c. COUNTY OF DEATH MONTGOMERY		
10a. STATE VA.			10b. COUNTY FAIRFAX			10c. CITY, TOWN OR LOCATION HERNDON			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1410 BAYSHIRE LA.				10f. ZIP CODE 22070				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) VIDEOGRAPHER				16b. KIND OF BUSINESS/INDUSTRY VIDEO		
17. FATHER'S NAME (First, Middle, Last) RICHARD W. BOYER				18. MOTHER'S NAME (First, Middle, Maiden Surname) NANCY N. BEALL						
19a. INFORMANT'S NAME (Type/Print) CATHY B. BOYER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		DATE 11/9		20c. LOCATION — City or Town, State RIVERDALE, MD.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypercalcemia DUE TO (OR AS A CONSEQUENCE OF): b. Relapsed non-Hodgkins Lymphoma DUE TO (OR AS A CONSEQUENCE OF): c. non-Hodgkins Lymphoma DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 4 days 2 yrs 9 yrs.		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) NA		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED NA		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) MD				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER  M.D.				29c. LICENSE NUMBER 0063273				29d. DATE SIGNED (Month, Day, Year) 11/8/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard Childs M.D. Bld 10 NCI Rm 226-H414, BETHESDA, Md.										
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE 						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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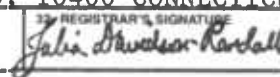
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95 36058

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JONAS BALIS				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 9 1995		3. TIME OF DEATH 1:00 p.m.	
4. SOCIAL SECURITY NUMBER 172-22-6308		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUGUST 11 1907	
8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA				9a. FACILITY NAME (If not institution, give street and number) 6020 CALIFORNIA CIRCLE #311		9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MARYLAND		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION ROCKVILLE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 6020 CALIFORNIA CIRCLE #311	
10f. ZIP CODE 20852				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER		16b. KIND OF BUSINESS/INDUSTRY MERCHANT			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) STEVEN BALIS (SON)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3610 TAYLOR STREET-CHEVY CHASE, MARYLAND 20815			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) JUDEAN		DATE 11-12		20c. LOCATION — City or Town, State OLNEY, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): MULTIPLE SMALL STROKES DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death 3 WEEKS 2 YEARS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTIPLE SMALL STROKES						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER  RICHARD POLLEN, MD				29c. LICENSE NUMBER 109577		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 10 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RICHARD POLLEN, MD, 10400 CONNECTICUT AVE. #606, KENSINGTON, MARYLAND 20895							
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

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95 36059

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Calvin P. Brockdorff				2. DATE OF DEATH MONTH DAY YEAR November 7, 1995				3. TIME OF DEATH 10:50 P M	
4. SOCIAL SECURITY NUMBER 579-03-6032		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	7. DATE OF BIRTH (Month, Day, Year) Aug. 15, 1912		8. BIRTHPLACE (State or Foreign Country) Virginia			
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Olney			9c. COUNTY OF DEATH Montgomery		
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Ashton			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 900 Ashland Drive				10f. ZIP CODE 20861		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bricklayer		16. KIND OF BUSINESS/INDUSTRY Masonry					
17. FATHER'S NAME (First, Middle, Last) Henri Brockdorff				18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther Hendricksen					
19a. INFORMANT'S NAME (Type/Print) Eva B. Brockdorff				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Ashland Drive, Ashton, Maryland 20861					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park 11/11		20c. LOCATION — City or Town, State Rockville, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									Approximate Interval Between Onset and Death YEARS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE RENAL DISEASE HYPERTENSION									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D38487		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 8, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) N. Gork and 1811 Prince Philip Dr, Olney MD 20832									
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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95 36060

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Lorimer Bakhshi				2. DATE OF DEATH MONTH DAY YEAR November 13 1995		3. TIME OF DEATH 2:30 A M	
4. SOCIAL SECURITY NUMBER 220-13-6605		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 1, 1926	
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Olney		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2206 Greenery Lane Apt. 102				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Asian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager		16b. KIND OF BUSINESS/INDUSTRY U.S. Commissary			
17. FATHER'S NAME (First, Middle, Last) K. S. Bakhshi				18. MOTHER'S NAME (First, Middle, Maiden Surname) Regina Michael			
19a. INFORMANT'S NAME (Type/Print) Dorothy Bakhshi				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2206 Greenery Lane Apt. 102, Silver Spring, MD 20906			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 11/18/95		20c. LOCATION — City or Town, State Silver Spring, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven D. Strand				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Severe interstitial pneumonitis</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>Respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. <i>Heart failure</i> DUE TO (OR AS A CONSEQUENCE OF):					
		d. <i>Inflammatory pericarditis over a year</i>					
		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Anemia</i> <i>upper gastro intestinal bleeding</i>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Nomicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N.A.		28b. TIME OF INJURY N.A. M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N.A.		28d. DESCRIBE HOW INJURY OCCURRED N.A.		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N.A.	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Byoung K. Lee M.D.				29c. LICENSE NUMBER D21033		29d. DATE SIGNED (Month, Day, Year) November 13, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BYOUNG K. LEE, M.D. 13000 Georgia Ave. Silver Spring, MD 20906							
31. DATE FILED (Month, Day, Year) NOV 14 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36061

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CONRAD RAYMOND BAYERLE						2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 7 1995		3. TIME OF DEATH 9:17 P M	
4. SOCIAL SECURITY NUMBER 476-18-0881		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 20, 1917		8. BIRTHPLACE (State or Foreign Country) Minnesota	
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER						9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Chevy Chase		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 2711 Spencer Road				10f. ZIP CODE 20815		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sergeant		16b. KIND OF BUSINESS/INDUSTRY U.S. Army			
17. FATHER'S NAME (First, Middle, Last) Raymond Bayerle						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Kuharski			
19a. INFORMANT'S NAME (Type/Print) Santina P. Bayerle						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2711 Spencer Road Chevy Chase, Maryland 20815			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 11/14/95 Arlington National Cemetery		20c. LOCATION — City or Town, State Arlington, Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Timothy G. Conner</i>						22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF): b. LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):									Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> I. MEHLMAN MD						29c. LICENSE NUMBER D-41110		29d. DATE SIGNED (Month, Day, Year) 11/9/95	
30. NAME AND ADDRESS OF PHYSICIAN WHO COMPLETED CAUSE OF DEATH (Type/Print) I. MEHLMAN MD						31. DATE FILED (Month, Day, Year) NOV 14 1995			
32. REGISTRAR'S SIGNATURE <i>[Signature]</i>						33. REGISTRAR'S NAME NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000 - 90

95 36062

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY GRACE BOWMAN				2. DATE OF DEATH MONTH NOV. DAY 12 YEAR 1995		3. TIME OF DEATH 0625 AM	
4. SOCIAL SECURITY NUMBER 012-05-4160		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 28, 1910	
8. BIRTHPLACE (State or Foreign Country) Massachusetts							
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 7717 Maryknoll Court				10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Public Schools	
17. FATHER'S NAME (First, Middle, Last) Anthony Ferrara				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Matera			
19a. INFORMANT'S NAME (Type/Print) Richard W. Bowman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7717 Maryknoll Court, Bethesda, Maryland 20817			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery November 15, 1995		20c. LOCATION — City or Town, State Silver Spring, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara J. McMullen-Laurence</i> MD0831				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → MALIGNANT LYMPHOMA							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph M. Haggerty MD</i>				29c. LICENSE NUMBER D32407		29d. DATE SIGNED (Month, Day, Year) Nov. 12th, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph M. Haggerty MD 9707 MEDICAL CTR DR. ROCKVILLE, MD 20850							
31. DATE FILED (Month, Day, Year) NOV 14 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Rindoff</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36063

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth R. Boland				2. DATE OF DEATH MONTH DAY YEAR November 11, 1995		3. TIME OF DEATH 9:55 A M	
4. SOCIAL SECURITY NUMBER 213-40-9567		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 6, 1913	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 7816 Maple Ridge Road	
10f. ZIP CODE 20814				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Executive Secretary		16b. KIND OF BUSINESS/INDUSTRY United States Government			
17. FATHER'S NAME (First, Middle, Last) Philip James Ryan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Madeline Byrne			
19a. INFORMANT'S NAME (Type/Print) Sheila E. Boland				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7816 Maple Ridge Road, Bethesda, Maryland 20814			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) November 20, 1995 Arlington National Cemetery		20c. LOCATION — City or Town, State Arlington, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara J. McMullen Lawrence</i>		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501					
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Acute Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 6 hours	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Coronary Artery and Valvular Heart Disease DUE TO (OR AS A CONSEQUENCE OF):				20 years	
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Urinary Sepsis							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James J. Foster MD</i>				29c. LICENSE NUMBER D04179		29d. DATE SIGNED (Month, Day, Year) November 13, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James Foster, M.D. 5530 Wisconsin Avenue, Chevy Chase, Maryland 20815-4330							
31. DATE FILED (Month, Day, Year) NOV 14 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36064

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WYNN BOYD				2. DATE OF DEATH MONTH DAY YEAR NOV. 13 1995		3. TIME OF DEATH 5:10 A.M.	
4. SOCIAL SECURITY NUMBER 577-32-0023		5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 28, 1902	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH MONTGOMERY			
9a. FACILITY NAME (If not institution, give street and number) Global Health Care Center				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 20600 Pratherstown Road				10f. ZIP CODE 20879		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Piano Tuner		16b. KIND OF BUSINESS/INDUSTRY Self	
17. FATHER'S NAME (First, Middle, Last) Westley Boyd				18. MOTHER'S NAME (First, Middle, Maiden Surname) Melinda Johnson			
19a. INFORMANT'S NAME (Type/Print) Arnold Boyd (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3661 S. Maryland Pkwy, #3 S, Las Vegas, NV 89109			
20a. METHOD OF DISPOSITION 1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 11/14 Alexandria, VA		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → A S C U D							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
a. Acute Cardiopulmonary Arrest							
DUE TO (OR AS A CONSEQUENCE OF):							
c. Senile Dementia							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HPBP							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>D.B. Patrick M.D.</i>				29c. LICENSE NUMBER D17729		29d. DATE SIGNED (Month, Day, Year) 11/13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G.B. Patrick MD 9221 Colesville Rd SS MD 20910							
31. DATE FILED (Month, Day, Year) NOV 15 1995				32. REGISTRAR'S SIGNATURE <i>John Anderson-Rodell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36065

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Roderick James Bowes				2. DATE OF DEATH MONTH DAY YEAR November 15, 1995		3. TIME OF DEATH 5:53 P. M.	
4. SOCIAL SECURITY NUMBER 215-58-8921		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 22 1951	
8. BIRTHPLACE (State or Foreign Country) Washington, DC				9a. CITY, TOWN OR LOCATION OF DEATH La Plata		9b. COUNTY OF DEATH Charles	
9c. FACILITY NAME (If not Institution, give street and number) Physicians Memorial Hospital							
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY St Mary's		10c. CITY, TOWN OR LOCATION Charlotte Hall		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7720 Kent Drive				10f. ZIP CODE 20622		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Automobile Body Repair		16b. KIND OF BUSINESS/INDUSTRY Automotive			
17. FATHER'S NAME (First, Middle, Last) Spencer Bowes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marjorie Wright			
19a. INFORMANT'S NAME (Type/Print) Jeanne A. Bowes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 78 Poolsville, Maryland 20838			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 11-16-95		20c. LOCATION — City or Town, State Alexandria, VA		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John A. Eberwein</i> M00173		22. NAME AND ADDRESS OF FACILITY J.H. Eberwein Mortuary 11855 Holy La #104 Waldorf, MD 20601					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Arteriosclerotic Cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>AM Hatt MD Charles C. Dwyer ME</i>				29c. LICENSE NUMBER D27343		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 16, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H Hatt, P.O. Box 1647 Waldorf, Md 20604							
31. DATE FILED (Month, Day, Year) NOV 20 1995				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36066

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MINNIE KATHERINE BENNETT				2. DATE OF DEATH MONTH NOVEMBER DAY 14 YEAR 1995		3. TIME OF DEATH 2:15 A.M.	
4. SOCIAL SECURITY NUMBER 146-30-7048		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 21, 1901	
8a. FACILITY NAME (If not institution, give street and number) CITIZENS NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH HAVRE DE GRACE		8. BIRTHPLACE (State or Foreign Country) Connecticut	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION Aberdeen		9c. COUNTY OF DEATH HARFORD	
10a. STATE Maryland		10b. COUNTY Harford		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 438 Grasmere Drive				10f. ZIP CODE 21001		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: /		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 5 College (1-4 or 5+) 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Public Education			
17. FATHER'S NAME (First, Middle, Last) Oscar (nmn) Voigtlander				16. MOTHER'S NAME (First, Middle, Maiden Surname) Louise (nmn) Wirth			
19a. INFORMANT'S NAME (Type/Print) Robert E. Walther				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 438 Grasmere Drive, Aberdeen, Maryland 21001			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairview Cemetery		DATE 11/18/95		20c. LOCATION — City or Town, State Westfield, N.J.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen A. Kuepfer</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHF - DEMENTIA - DIVERTICULOSIS - - DVA - OSTEOPOROSIS							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>E. Biardo MD</i>		29c. LICENSE NUMBER 042800		29d. DATE SIGNED (Month, Day, Year) 11/15/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. Biardo MD, LMC 3145 Linton Ave, H&C Bldg, 21078							
31. DATE FILED (Month, Day, Year) 11/17/95		32. REGISTRAR'S SIGNATURE <i>John D. Parker</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 36067

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Helen Jeanne Brightbill</i>				2. DATE OF DEATH MONTH DAY YEAR <i>November 13th 1995</i>		3. TIME OF DEATH <i>8:20 P M</i>	
4. SOCIAL SECURITY NUMBER <i>181-22-7558</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>67</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 18, 1928</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>				9. CITY, TOWN OR LOCATION OF DEATH <i>Fallston</i>		10. COUNTY OF DEATH <i>Harford</i>	
11. FACILITY NAME (If not institution, give street and number) <i>Fallston General Hospital</i>				12. CITY, TOWN OR LOCATION <i>Bel Air</i>		13. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
14. STATE <i>Maryland</i>				15. COUNTY <i>Harford</i>		16. CITY, TOWN OR LOCATION <i>Bel Air</i>	
17. STREET AND NUMBER <i>950 Richwood Road, Apt. D</i>				18. ZIP CODE <i>21014</i>		19. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
20. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		21. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		23. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
24. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i>		25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Teacher</i>		26. KIND OF BUSINESS/INDUSTRY <i>Public Education</i>			
27. FATHER'S NAME (First, Middle, Last) <i>John Albert Hoffman</i>				28. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Susan Ray Caley</i>			
29. INFORMANT'S NAME (Type/Print) <i>Donna L. Clauer</i>				30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1909 Wheel Road, Bel Air, Maryland 21015</i>			
31. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Union Cemetery</i>		33. DATE <i>Nov. 16,</i>		34. LOCATION — City or Town, State <i>1995 Duncannon, PA</i>	
35. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jelly McComas</i>				36. NAME AND ADDRESS OF FACILITY <i>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009</i>			
37. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Metastatic Carcinoma, Both Lungs</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <i>4 years</i>	
		b. <i>Metastatic Carcinoma, Liver</i> DUE TO (OR AS A CONSEQUENCE OF):				<i>4 years</i>	
		c. <i>Carcinoma, Bilateral Breasts</i> DUE TO (OR AS A CONSEQUENCE OF):				<i>6 years</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
38. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i> <i>Atherosclerotic Cardiovascular Disease</i>							
39. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				40. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		41. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
42. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		43. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
44. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		45. DATE OF INJURY (Month, Day, Year)		46. TIME OF INJURY <i>M</i>		47. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		48. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		49. DESCRIBE HOW INJURY OCCURRED			
		50. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
51. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
52. SIGNATURE AND TITLE OF CERTIFIER <i>Kermit P. Bonovich MD Physician</i>				53. LICENSE NUMBER <i>D05593</i>		54. DATE SIGNED (Month, Day, Year) <i>November 14, 1995</i>	
55. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Kermit P. Bonovich MD 754 Hickory Avenue Bel Air Maryland 21014</i>							
56. DATE FILED (Month, Day, Year) <i>NOV 15 1995</i>		57. REGISTRAR'S SIGNATURE <i>Jana Davidson-Rodall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 36068

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Veronica Esther BALCEROWICZ				2. DATE OF DEATH MONTH 11 DAY 12 YEAR 95		3. TIME OF DEATH 8:50 A M	
4. SOCIAL SECURITY NUMBER 216-12-3500		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 1, 1905	
9a. FACILITY NAME (If not institution, give street and number) IVY-HALL Geriatric Center				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Joppa		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 516 Old Philadelphia Road				10f. ZIP CODE 21085		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner and Operator		16b. KIND OF BUSINESS/INDUSTRY Retail Grocery			
17. FATHER'S NAME (First, Middle, Last) Alexander (u/k) Golas				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna (u/k) Kulis			
19a. INFORMANT'S NAME (Type/Print) Anthony J. Balcerowicz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 Old Philadelphia Road, Joppa, Maryland 21085			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanislaus Cemetery		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen A. Hughes</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Vascular emboli.							
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): Dilated Cardiomyopathy							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① CAD / Pacemaker / Syncope episodes ② HTN ③ DM							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Malika Wasbani MD</i>				29c. LICENSE NUMBER D-38754		29d. DATE SIGNED (Month, Day, Year) 11-13-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MALIKA WASBANI 100 N. BROADWAY, BALTIMORE, MD - 21231							
31. DATE FILED (Month, Day, Year) NOV 15 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36069

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Fannie Lee BRIGHTHOP				2. DATE OF DEATH MONTH November DAY 12 , YEAR 1995		3. TIME OF DEATH 0355 AM	
4. SOCIAL SECURITY NUMBER 289-24-2460		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 20, 1923	
8a. FACILITY NAME (If not institution, give street and number) Doctors Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Lanham		8c. COUNTY OF DEATH Prince Georges	
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Capitol Heights		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1325 Oates Street				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Private Industry			
17. FATHER'S NAME (First, Middle, Last) Charlis Broadwater				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Briscoe			
19a. INFORMANT'S NAME (Type/Print) Veronica Winston				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1325 Oates St., Capitol Heights, Md.			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park 11/18/95		20c. LOCATION — City or Town, State Landover, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.G. Jeffers</i>				22. NAME AND ADDRESS OF FACILITY Frazier's Funeral Home 389 Rhode Island Av., NW, Washington, D.C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute cardiorespiratory failure DUE TO (OR AS A CONSEQUENCE OF): a. Aspiration pneumonia possible DUE TO (OR AS A CONSEQUENCE OF): b. Stated post cerebral vascular accident DUE TO (OR AS A CONSEQUENCE OF): c. arteriosclerotic cardiovascular disease						Approximate interval Between Onset and Death 5 wks	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>MD</i>				29c. LICENSE NUMBER 000081		29d. DATE SIGNED (Month, Day, Year) 11-14-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr David Anders 8824 Cunningham Dr Berwyn Heights 2074							
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE <i>John Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 36070

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Bailey				2. DATE OF DEATH MONTH DAY YEAR November 15, 1995				3. TIME OF DEATH 7:15 P.M.	
4. SOCIAL SECURITY NUMBER 018-18-6427		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	7. DATE OF BIRTH (Month, Day, Year) April 15, 1921		8. BIRTHPLACE (State or Foreign Country) Massachusetts			
9a. FACILITY NAME (If not institution, give street and number) Prince George's Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly			9c. COUNTY OF DEATH Prince George's		
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Riverdale			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 6910 Furman Parkway				10f. ZIP CODE 20737			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Elementary School Teacher			16b. KIND OF BUSINESS/INDUSTRY Educational System		
17. FATHER'S NAME (First, Middle, Last) Peter F. Wynne				18. MOTHER'S NAME (First, Middle, Maiden Surname) Brigid Donavon					
19a. INFORMANT'S NAME (Type/Print) William A. Bailey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6910 Furman Parkway Riverdale, Maryland 20737					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 11/17/1995 Alexandria, Virginia			20c. LOCATION — City or Town, State		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>H. Constance Gasch</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20781					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Cardiac Arrest</i> b. <i>Arteriosclerotic Heart Disease</i> c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute Pyelonephritis</i>								Approximate interval Between Onset and Death <i>10 min</i> <i>15 years</i>	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas Maloney MD</i>				29c. LICENSE NUMBER D07479			29d. DATE SIGNED (Month/Day, Year) 11/16, 95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas Maloney, M.D., 4814 71st Avenue Hyattsville, Maryland 20784-1607									
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

6876

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOV 7 1932
J. J. VON

95 36071

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DENISE ARLENE BARRON				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 5 1995		3. TIME OF DEATH 10:05 P M	
4. SOCIAL SECURITY NUMBER 577-80-2389		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 39 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/11/56	
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE D.C.		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Washington		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 300 Division Ave., N.E.				10f. ZIP CODE 20019		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) None		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled		16b. KIND OF BUSINESS/INDUSTRY None			
17. FATHER'S NAME (First, Middle, Last) Willie Lewis Barron				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred A. Bennett			
19a. INFORMANT'S NAME (Type/Print) Mildred A. Barron				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington Nat'l. Cem.		DATE 11/14/95		20c. LOCATION — City or Town, State Ft. Myer, Va.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry H. Pratt</i>				22. NAME AND ADDRESS OF FACILITY H.S. Washington & Sons, inc. 4925 Burroughs Ave., N.E.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SICKLE CELL CRISIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Scott Haveren MD</i>				29c. LICENSE NUMBER RES-000		29d. DATE SIGNED (Month, Day, Year) 06 NOV 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. HAVENER, LT, MC, USN				31. DATE FILED (Month, Day, Year) NOV 13 1995			
32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11022 2.

Handwritten text at the bottom of the page, possibly a signature or date.

95 36072

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nellie Estelle Bladen				2. DATE OF DEATH MONTH DAY YEAR November 4, 1995		3. TIME OF DEATH 6:00 AM	
4. SOCIAL SECURITY NUMBER 578 34 2112		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) APRIL 8, 1922	
8. BIRTHPLACE (State or Foreign Country) Washington D.C.				9a. FACILITY NAME (If not institution, give street and number) 9101 Fifth Street		9b. CITY, TOWN OR LOCATION OF DEATH Lanham	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Lanham				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 9101 Fifth Street	
10f. ZIP CODE 20706				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervision		16b. KIND OF BUSINESS/INDUSTRY Computer Manufacturing	
17. FATHER'S NAME (First, Middle, Last) Melvin Lewis Kendrick				18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia E. Robinson			
19a. INFORMANT'S NAME (Type/Print) William L. Bladen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12602 Knowledge Lane Bowie Maryland 20715			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 11/7/95		20c. LOCATION — City or Town, State Brentwood Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres.				22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. CA of Breast DUE TO (OR AS A CONSEQUENCE OF): 3 years							
b. CA of Vagina DUE TO (OR AS A CONSEQUENCE OF): 6 months							
c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): 15 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Ata Moshedy M.D.				29c. LICENSE NUMBER D09179		29d. DATE SIGNED (Month, Day, Year) Nov. 6, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ata Moshedy M.D. 7305 Hanover Parkway Greenbelt, Maryland 20770							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE Julia D. Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Philip H. Bath Jr.				2. DATE OF DEATH MONTH DAY YEAR October 31, 1995		3. TIME OF DEATH 3:45 PM M	
4. SOCIAL SECURITY NUMBER 579 26 0861		5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F 1		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 2, 1926	
8. BIRTHPLACE (State or Foreign Country) Washington D.C.				9a. FACILITY NAME (If not institution, give street and number) Bowie Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH Bowie	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Bowie				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 3009 Trinity Drive	
10f. ZIP CODE 20715				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Naval Ordnance Technician		16b. KIND OF BUSINESS/INDUSTRY Naval Surface Weapons Laboratory	
17. FATHER'S NAME (First, Middle, Last) Philip H. Bath Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jane M Petrie			
19a. INFORMANT'S NAME (Type/Print) Veronica A. Bath				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3009 Trinity Drive Bowie Maryland 20715			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veteran's Cemetery 11/6/95 Cheltenham Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres				22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Massive Myocardial infarction Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Hyperlipidemia b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 2 hrs.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Rita Farahi				29c. LICENSE NUMBER D 43446		29d. DATE SIGNED (Month, Day, Year) 11/01/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROINTAN FARAH-FAR. 4000 Mitchellville road B216 Bowie MD 20716							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Agnes Marie Brooks				2. DATE OF DEATH MONTH DAY YEAR November 7, 1995				3. TIME OF DEATH 8:02 a m	
4. SOCIAL SECURITY NUMBER 220-44-8679		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) November 5, 1899				8. BIRTHPLACE (State or Foreign Country) Washington, DC					
9a. FACILITY NAME (If not institution, give street and number) Hyattsville Health Care Center				9b. CITY, TOWN OR LOCATION OF DEATH Hyattsville				9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Hyattsville			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO									
10e. STREET AND NUMBER 6500 Riggs Road				10f. ZIP CODE 20783				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Statistical Clerk				16b. KIND OF BUSINESS/INDUSTRY U.S. Government	
17. FATHER'S NAME (First, Middle, Last) William Armstrong Brooks				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Anderson					
19a. INFORMANT'S NAME (Type/Print) Mary H. Sharer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6629 Paxton Road, Rockville, Maryland 20852					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 11/9/95		DATE 11/9/95		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis Gasch</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac and Respiratory Arrest</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Aggravated Process</i> <i>Hypertension</i> <i>COPD (Chronic Obstructive Pulmonary Disease)</i>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Legal Blind due to Cataract</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jai S. Cho, M.D.</i>				29c. LICENSE NUMBER MD D19496				29d. DATE SIGNED (Month, Day, Year) November 7, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Jai S. Cho, M.D. 14333 Laurel-Bowie Road, Suite 206, Laurel, Maryland 20708									
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>Jai S. Cho</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36075

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Freeman A. Bussey			2. DATE OF DEATH MONTH November DAY 11 YEAR 1995		3. TIME OF DEATH 4:45A M
4. SOCIAL SECURITY NUMBER 256-07-1005	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	7. DATE OF BIRTH (Month, Day, Year) MAR. 31, 1914	8. BIRTHPLACE (State or Foreign Country) WASH, GA	
9a. FACILITY NAME (If not institution, give street and number) 3912 WALLACE RD			9b. CITY, TOWN OR LOCATION OF DEATH N. BRENTWOOD		9c. COUNTY OF DEATH PG
10a. STATE MD			10b. COUNTY PG		10c. CITY, TOWN OR LOCATION N. BRENTWOOD
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			10e. STREET AND NUMBER 3912 WALLACE RD		
10f. ZIP CODE 20722			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES ARMY 1944 - 1947		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COST ANALYST		16b. KIND OF BUSINESS/INDUSTRY DEFENSE DEPT.			
17. FATHER'S NAME (First, Middle, Last) ROBERT BUSSEY			18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE DAVIS		
19a. INFORMANT'S NAME (Type/Print) FREEMAN A. BUSSEY, JR.			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3912 WALLACE RD N. BRENTWOOD 20722		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of institution, cemetery, or other place) MARYLAND NATL. MEMO. PK 11/16		20c. LOCATION — City or Town, State LAUREL, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Theodore C. Pinckney</i>			22. NAME OF FUNERAL HOME PINCKNEY & SPANGLER FUNERAL HOME 524-8th STREET, N.E., WASH, DC 20002		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple myeloma DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusta P. Rodriguez MD</i>			29c. LICENSE NUMBER 221230		29d. DATE SIGNED (Month, Day, Year) November 11, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez MD, 5029 Rayburn Ct. Cp. Sp. Md 20748					
31. DATE FILED (Month, Day, Year) NOV 15 1995		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Clare Anne Beach				2. DATE OF DEATH MONTH DAY YEAR November 9, 1995		3. TIME OF DEATH 1:36 P M	
4. SOCIAL SECURITY NUMBER 285-18-5262		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 13, 1921	
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Riverdale	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 5908 61st Avenue				10f. ZIP CODE 20737		10g. COUNTRY OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Housewife		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Anthony Jasinski				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary M. Gralka			
19a. INFORMANT'S NAME (Type/Print) James E. Beach				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5908 61st Avenue, Riverdale, Md. 20737			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 11/17/95 Arlington, Va.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.B. Geiser				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home - 4739 Baltimore Avenue, Hyattsville, Md. 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RENAL FAILURE Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST AND CONGESTIVE HEART FAILURE DUE TO NEPHROSCLEROSIS AND CORONARY ARTERY DISEASE Approximate Interval Between Onset and Death 3 MONTH							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES - OBESITY - CORONARY BYPASS SURGERY IN AUG. 95 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John Neimat, M.D.				29c. LICENSE NUMBER MD - D18551		29d. DATE SIGNED (Month, Day, Year) 10 NOV. 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAMIR NEIMAT, MD. 7610 CARROLL AV. TAKOMA PARK, MD, 20912							
31. DATE FILED (Month, Day, Year) NOV 15 1995		32. REGISTRAR'S SIGNATURE John Neimat					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 36077

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUTH BROWN				2. DATE OF DEATH MONTH 11 DAY 10 YEAR 1995		3. TIME OF DEATH 10:05 P M	
4. SOCIAL SECURITY NUMBER 247-16-1915		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 18, 1907	
8. BIRTHPLACE (State or Foreign Country) S.C.				9. FACILITY NAME (If not institution, give street and number) Randolph Hills Nursing Center			
10. CITY, TOWN OR LOCATION OF DEATH Wheaton, MD				11. COUNTY OF DEATH Montgomery			
12. STATE S.C.		13. COUNTY Richland		14. CITY, TOWN OR LOCATION Columbia		15. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
16. STREET AND NUMBER 4542 Robney Drive				17. ZIP CODE 29209		18. CITIZEN OF WHAT COUNTRY? USA	
19. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: Black	
23. DECEDENT'S EDUCATION (Specify only highest grade completed) 7 Elementary/Secondary (0-12) College (1-4 or 5+)		24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laundry Worker		25. KIND OF BUSINESS/INDUSTRY Civil Service			
26. FATHER'S NAME (First, Middle, Last) Mitchell Dessausure				27. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie Richardson			
28. INFORMANT'S NAME (Type/Print) Hattie Ruth Jackson				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20333 Waters Row Terr. Germantown MD 20871			
30. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Nov. 16, 1995 Friendship Baptist Church		32. LOCATION — City or Town, State Columbia, S.C.			
33. SIGNATURE OF FUNERAL SERVICE LICENSEE Roger J. Jackson				34. NAME AND ADDRESS OF FACILITY Palmer Memorial Chapel 1200 Fontaine Place Columbia S.C. 29223			
35. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPTICEMIA DUE TO (OR AS A CONSEQUENCE OF): a. WASTING b. PROGRESSIVE DEMENTIA c. DIABETES MELLITUS; HYPERTENSION d. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS; HYPERTENSION							
37. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		38. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		39. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		40. DATE OF INJURY (Month, Day, Year) NOV 16 1995	
41. TIME OF INJURY M		42. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		43. DESCRIBE HOW INJURY OCCURRED			
44. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				45. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
46. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
47. SIGNATURE AND TITLE OF CERTIFIER Martin C. Staggel				48. LICENSE NUMBER D08944		49. DATE SIGNED (Month, Day, Year) 11/11/95	
50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTIN C. STAGGEL, MD 3720 FARRAGUT AVE KENSINGTON, MD 20895							
51. DATE FILED (Month, Day, Year) NOV 16 1995				52. REGISTRAR'S SIGNATURE John Andrew Ruckel			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 36078

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ean C. Chea				2. DATE OF DEATH MONTH DAY YEAR November 10, 1995		3. TIME OF DEATH 7:16 P M	
4. SOCIAL SECURITY NUMBER 586-58-5880		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 5, 1916	
9a. FACILITY NAME (If not institution, give street and number) Laurel Regional Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Laurel		9c. COUNTY OF DEATH Prince Georges	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1020 Gresham Road				10f. ZIP CODE 20904		10g. CITIZEN OF WHAT COUNTRY? USA Permanent Resident	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Asian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Civil Servant		15b. KIND OF BUSINESS/INDUSTRY National Bank			
17. FATHER'S NAME (First, Middle, Last) Rau Chea				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eng Chi			
19a. INFORMANT'S NAME (Type/Print) Say Chea				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18245 Lost Knife Circle, Gaithersburg, MD 20879			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		DATE 11/18		20c. LOCATION — City or Town, State Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J. Gugen</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): <i>coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1 month
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. H. D.</i>				29c. LICENSE NUMBER D24283		29d. DATE SIGNED (Month, Day, Year) Nov 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. YOUSUF M.D. 3450 Fort Meade Road Laurel MD 20702							
31. DATE FILED (Month, Day, Year) NOV 15 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


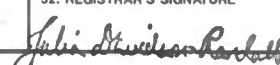
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36079

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Eugene A. Catalano				2. DATE OF DEATH MONTH DAY YEAR Nov 10, 1995				3. TIME OF DEATH 1:02 A M					
4. SOCIAL SECURITY NUMBER 218-24-6954		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Feb 12, 1932		8. BIRTHPLACE (State or Foreign Country) Washington, DC			
9a. FACILITY NAME (If not institution, give street and number) Howard County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Columbia				9c. COUNTY OF DEATH Howard					
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Clarksville				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 11737 Bragdon Wood				10f. ZIP CODE 21029				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean Conflict		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner				16b. KIND OF BUSINESS/INDUSTRY Restaurant					
17. FATHER'S NAME (First, Middle, Last) Vincent Catalano						18. MOTHER'S NAME (First, Middle, Maiden Surname) Concetta Scalco							
19a. INFORMANT'S NAME (Type/Print) Bettina S. Catalano				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11737 Bragdon Wood, Clarksville, MD 21029									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Columbia Memorial Park Nov 13				20c. LOCATION — City or Town, State Columbia, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aspiration										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Levan Kuck MD						29c. LICENSE NUMBER MD 025604		29d. DATE SIGNED (Month, Day, Year) Nov 10 95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Levan Kuck Howard County Hospital, Columbia, MD 21044													
31. DATE FILED (Month, Day, Year) NOV 15 1995				32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36080

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AMY CHAMBERLIN				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 13, 1995		3. TIME OF DEATH 1640 M	
4. SOCIAL SECURITY NUMBER 230-34-6874		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 12, 1930	
8. BIRTHPLACE (State or Foreign Country) Crisfield, MD				9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH TAKOMA PARK, MARYLAND	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 700 Thayer Avenue	
10f. ZIP CODE 20910				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mathematician		16b. KIND OF BUSINESS/INDUSTRY Naval Surface Weapons	
17. FATHER'S NAME (First, Middle, Last) Robert L. Chamberlin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Cochrane			
19a. INFORMANT'S NAME (Type/Print) Robert Chamberlin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1612 Q St., NW, Apt. E, Washington, DC 20004			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 11/16/95		20c. LOCATION — City or Town, State Alexandria, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. respiratory failure second to multiple sclerosis 1 year DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Paraparesis, and gluteal skin ulceration							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Deborah B Goldberg MD				29c. LICENSE NUMBER 1017423		29d. DATE SIGNED (Month, Day, Year) 11/14/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DEBORAH B GOLDBERG, 8700 GEORGIA AVE, SILVER SPRING MD 20910							
31. DATE FILED (Month, Day, Year) NOV 16 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68766

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36081

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Frank Campanile				2. DATE OF DEATH MONTH DAY YEAR November 9, 1995				3. TIME OF DEATH 11:05 P.M.	
4. SOCIAL SECURITY NUMBER 220-70-4366		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 17, 1959		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 12806 Atherton Drive				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 12806 Atherton Drive				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bricklayer		16b. KIND OF BUSINESS/INDUSTRY Construction					
17. FATHER'S NAME (First, Middle, Last) Vitantonio Campanile				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Campanile					
19a. INFORMANT'S NAME (Type/Print) Vitantonio Campanile				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12806 Atherton Drive Silver Spring, Maryland 20906					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 11/10/95		20c. LOCATION - City or Town, State Alexandria, Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Ramsey</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Progressive multifocal leukoencephalopathy</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Acquired immunodeficiency syndrome</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>HIV infection</i> DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 4 mos 20 mos 3 yr 8 mos	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Lung abscess March, 1992</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Katharine Waldmann, M.D.</i>				29c. LICENSE NUMBER D08818		29d. DATE SIGNED (Month, Day, Year) Nov 10, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KATHARINE WALDMANN, MD 2000 Dennis Ave. Silver Spring, MD 20902									
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36082

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Vaderia Alberta Campbell		2. DATE OF DEATH MONTH DAY YEAR Nov 8 1995		3. TIME OF DEATH 7:43 P M	
4. SOCIAL SECURITY NUMBER 280-16-3430		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.	
7. DATE OF BIRTH (Month, Day, Year) October 30, 1916		8. BIRTHPLACE (State or Foreign Country) Ohio			
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Wheaton	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 11525 Soward Drive		10f. ZIP CODE 20902	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Harry St. John		18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl Unknown			
19a. INFORMANT'S NAME (Type/Print) Isaac W. Campbell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11525 Soward Drive, Wheaton, MD 20902			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Cemetery 11/11/95		20c. LOCATION — City or Town, State Rockville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven D. Strand		22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ATHEROSCLEROTIC CORONARY VASCULAR DISEASE</u>					
DUE TO (OR AS A CONSEQUENCE OF):					
b. DUE TO (OR AS A CONSEQUENCE OF):					
c. DUE TO (OR AS A CONSEQUENCE OF):					
d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Jeanne P. Asher MD		29c. LICENSE NUMBER D34032		29d. DATE SIGNED (Month, Day, Year) 11/9/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEANNE P. ASHER MD 3720 FARRAGUT AVE, KENSINGTON MD 20895					
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE John Davidson-Russell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36083

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George H. Cornell				2. DATE OF DEATH MONTH DAY YEAR Nov. 10 '95				3. TIME OF DEATH 10 10 P M					
4. SOCIAL SECURITY NUMBER 577-09-4794		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) April 20, 1914		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.	
9a. FACILITY NAME (If not institution, give street and number) 3400 Oberon Street						9b. CITY, TOWN OR LOCATION OF DEATH Kensington				9c. COUNTY OF DEATH Montgomery			
10a. STATE Maryland				10b. COUNTY Montgomery				10c. CITY, TOWN OR LOCATION Kensington				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3400 Oberon Street						10f. ZIP CODE 20895				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942-1946		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Military Sales Representative				16b. KIND OF BUSINESS/INDUSTRY U.S. Air Force					
17. FATHER'S NAME (First, Middle, Last) George H. Cornell						18. MOTHER'S NAME (First, Middle, Maiden Surname) Lena Vogt							
19a. INFORMANT'S NAME (Type/Print) Frances S. Cornell						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3400 Oberon Street Kensington, Maryland 20895							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 11/14/95				20c. LOCATION — City or Town, State Suitland, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Ramsey				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure Due to (or as a consequence of): b. Arteriosclerotic Heart Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral Vascular Insufficiency										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) Nov		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER John B. Umhau MD						29c. LICENSE NUMBER D11024		29d. DATE SIGNED (Month, Day, Year) 11/10/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John B. Umhau MD, 8805 Camp Ave., Chevy Chase Md. 20815													
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36084

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Irene L. Crawford		2. DATE OF DEATH MONTH DAY YEAR Nov. 7, 1995		3. TIME OF DEATH 6:45 p. M	
4. SOCIAL SECURITY NUMBER 218-30-3733		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.	
7. DATE OF BIRTH (Month, Day, Year) Jan. 23, 1903		8. BIRTHPLACE (State or Foreign Country) Virginia			
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Cabin John	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 6934 Seven Locks Road		10f. ZIP CODE 20818	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY None	
17. FATHER'S NAME (First, Middle, Last) Anderson Colbert		18. MOTHER'S NAME (First, Middle, Maiden Surname) Maggie Gibson			
19a. INFORMANT'S NAME (Type/Print) Charles H. Crawford (Son)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6934 Seven Locks Rd., Cabin John, MD 20818			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Mem. Cem. 11/13 Suitland, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Brandler</i>		22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST MULTI-INFARCT DEMENTIA DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTI-INFARCT DEMENTIA		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martin C. Shargel M.D.</i>		29c. LICENSE NUMBER D08944	
29d. DATE SIGNED (Month, Day, Year) 11/7/95		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTIN C. SHARGEL, M.D. 3720 FARRAGUT AVE KENSINGTON, MD 20895			
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


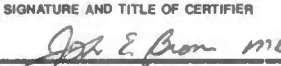

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36085

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARK CRYTS				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 5 1995				3. TIME OF DEATH P M 11:17 P M			
4. SOCIAL SECURITY NUMBER 017-50-7739		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 33 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 8, 1962		8. BIRTHPLACE (State or Foreign Country) CALIFORNIA			
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA				9c. COUNTY OF DEATH MONTGOMERY			
10a. STATE D.C.		10b. COUNTY NONE		10c. CITY, TOWN OR LOCATION WASHINGTON				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1720 20th ST. N.W. #1				10f. ZIP CODE 20009				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1980-1985		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FLORIST				16b. KIND OF BUSINESS/INDUSTRY FLOWER STORE			
17. FATHER'S NAME (First, Middle, Last) ARLEN LEON CRYTS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY A. DAVIS							
19a. INFORMANT'S NAME (Type/Print) MARY A. NEAL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 A CENTER ST., YORK BEACH, ME. 03910							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY 11/9				20c. LOCATION — City or Town, State RIVERDALE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0091				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMOCYSTIS CARENII PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. ACQUIRED IMMUNE DEFICIENCY SYNDROME DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death MOS. YRS.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 11		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
				28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER  J. E. BROWN, MC, USNR				29c. LICENSE NUMBER D-42718		29d. DATE SIGNED (Month, Day, Year) 11/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. E. BROWN, LCDR, MC, USNR				31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 36086

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dolores Margaret Callahan				2. DATE OF DEATH MONTH DAY YEAR November 12, 1995		3. TIME OF DEATH HOURS MIN. AM/PM 8:05 A M	
4. SOCIAL SECURITY NUMBER 160-26-6327		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 62		7. DATE OF BIRTH (Month, Day, Year) May 15, 1933	
8a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Olney		8c. COUNTY OF DEATH Montgomery	
9a. STATE Maryland		9b. COUNTY Montgomery		9c. CITY, TOWN OR LOCATION Silver Spring		9d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER 12823 Matey Road				10b. ZIP CODE 20906		10c. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Robert W. Dougherty				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret V. Gormley			
19a. INFORMANT'S NAME (Type/Print) Kathleen M. Winters				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12823 Matey Road Silver Spring, Maryland 20906			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 11/15/95 Silver Spring, Maryland		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Ramsey				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC SQUAMOUS CELL CANCER OF LUNG DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval between Onset and Death 8 months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD [Chronic Obstructive Pulmonary Disease] HYPERTENSION							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY HOURS MIN. AM/PM M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER P. Henjum, MD Attending Physician				29c. LICENSE NUMBER D35045		29d. DATE SIGNED (Month, Day, Year) November 12, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PHILIP HENJUM, MD 3416 OLANWOOD CT. #200 OLNEY, MD 20832							
31. DATE FILED (Month, Day, Year) NOV 15 1995		32. REGISTRAR'S SIGNATURE Jane Davidson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36087

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Martha GERTRUDE Crowe</i>				2. DATE OF DEATH MONTH <i>11</i> DAY <i>13</i> YEAR <i>95</i>		3. TIME OF DEATH <i>11:08 P</i>	
4. SOCIAL SECURITY NUMBER <i>577-48-5440</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>58</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>January 12, 1937</i>	
8. BIRTHPLACE (State or Foreign Country) <i>West Virginia</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Southern Maryland Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Clinton</i>	
9c. COUNTY OF DEATH <i>Prince Georges</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Charles</i>	
10c. CITY, TOWN OR LOCATION <i>La Plata</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>20362 La Plata Road</i>	
10f. ZIP CODE <i>20646</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify:				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>7</i> College (1-4 or 5+) <i></i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Home maker</i>				16b. KIND OF BUSINESS/INDUSTRY <i>At Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Alven Denton Dunbar</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Beulah Gertrude Tinch</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Rose M. Beach</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3047 Heath coate Road, Waldorf, Md. 20602</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Trinity Memorial Gardens 11/17/95, Waldorf, Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>D. C. Echols</i> M-00174				22. NAME AND ADDRESS OF FACILITY <i>AREHART-ECHOLS FUNERAL HOME, INC. P.O. BOX 567, LA PLATA, MD. 20646</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Massive subarachnoid hemorrhage</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>Ruptured intracranial aneurysm</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sharon L. Marseles, M.D.</i>				29c. LICENSE NUMBER <i>D22026</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/14/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Sharon L. Marseles, M.D.</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 17 1995</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36088

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JoAnn (nmn) Clark				2. DATE OF DEATH MONTH DAY YEAR November 17, 1995		3. TIME OF DEATH 2:45 AM	
4. SOCIAL SECURITY NUMBER 213-38-5909		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 19, 1941	
8. BIRTHPLACE (State or Foreign Country) North Carolina				9a. FACILITY NAME (If not institution, give street and number) 1516 Castleton Road		9b. CITY, TOWN OR LOCATION OF DEATH Darlington	
9c. COUNTY OF DEATH Harford				10a. STATE Maryland		10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Darlington				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1516 Castleton Road	
10f. ZIP CODE 21034				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner and Operator		16b. KIND OF BUSINESS/INDUSTRY Janitorial Service	
17. FATHER'S NAME (First, Middle, Last) Troy (nmn) Green				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna V. Church			
19a. INFORMANT'S NAME (Type/Print) George F. Clark				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1516 Castleton Road, Darlington, Maryland 21034			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dublin Southern Cemetery 11/20/95 Deerfield, Maryland		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Healy K. McComas</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>ISCHEMIC CARDIOMYOPATHY</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>DIABETES</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Peripheral Vascular Disease / Renal insufficiency</i> <i>Coronary Artery Disease</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M		28c. INJURY AT WORK 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>K. McComas MD</i>				29c. LICENSE NUMBER D022843		29d. DATE SIGNED (Month, Day, Year) 11/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PHILLIPS / 2005 ROCK SPRING RD FOREST HILL MD 20702							
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36089

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELAINE WALKER CARROLL				2. DATE OF DEATH MONTH DAY YEAR November 10, 1995		3. TIME OF DEATH 9:50 P. M.	
4. SOCIAL SECURITY NUMBER 216-24-6554		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/5/1927	
8a. FACILITY NAME (If not institution, give street and number) Stella Maris				8b. CITY, TOWN OR LOCATION OF DEATH Towson		8c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Aberdeen		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 323 Rogers Street				10f. ZIP CODE 21001		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bank Manager		16b. KIND OF BUSINESS/INDUSTRY Banking			
17. FATHER'S NAME (First, Middle, Last) G. Robert Walker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Holloway			
19a. INFORMANT'S NAME (Type/Print) Joseph W. Moore				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 233 Ambleside Dr., Severna Park, MD 21146			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harford Memorial Gdns. 11/13		20c. LOCATION — City or Town, State Aberdeen, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kirsten Amy Unglesbee				22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → LIVER METASTASES							23 mos. 5 yrs.
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. COLON CANCER							
c. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kendall Faulkner				29c. LICENSE NUMBER D25643		29d. DATE SIGNED (Month, Day, Year) 11/13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) NOV 15 1995		32. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 36090

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Aunnette CARR			2. DATE OF DEATH MONTH DAY YEAR November 9, 1995		3. TIME OF DEATH 7:35 A.M.	
4. SOCIAL SECURITY NUMBER 220-20-7625	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	7. DATE OF BIRTH (Month, Day, Year) March 18, 1912	8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT						
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION White Marsh		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 11303 Beach Road		10f. ZIP CODE 21162		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Inspector		16b. KIND OF BUSINESS/INDUSTRY U.S. Government		
17. FATHER'S NAME (First, Middle, Last) James (u/k) Loomis			18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna (u/k) Grimes			
19a. INFORMANT'S NAME (Type/Print) Dorothy L. Ryan			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Kenmore Ave., Bel Air, Maryland 21014			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removed from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cokesbury U.M. Cemetery 11/12/95		20c. LOCATION — City or Town, State Abingdon, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Bone Metastasis DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death 1 year		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Unknown primary cancer DUE TO (OR AS A CONSEQUENCE OF):		2 years		
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):				
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER 			29c. LICENSE NUMBER P09192		29d. DATE SIGNED (Month, Day, Year) November 9, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Kim, M.D. 9000 Franklin Square Drive Baltimore, MD 21237						
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE 				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 36091

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BARBARA JEAN CHARLES				2. DATE OF DEATH MONTH DAY YEAR Nov 8 1995		3. TIME OF DEATH 9:50 P M	
4. SOCIAL SECURITY NUMBER 267-58-6069		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 6, 1923	
8. FACILITY NAME (If not institution, give street and number) Good Samaritan Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH W. Virginia	
10a. STATE Texas				10b. COUNTY Polk		10c. CITY, TOWN OR LOCATION Livingston	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 101 Rainbow Drive, #5905				10f. ZIP CODE 77351		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 8+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Harry --- Sturm				18. MOTHER'S NAME (First, Middle, Maiden Surname) Vivian --- Hammer			
19a. INFORMANT'S NAME (Type/Print) Robert F. Charles				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Rainbow Drive #5905, Livingston, Tx. 77351			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris & Co. 11-9-95		20c. LOCATION — City or Town, State W. Chester, Pa.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CANCER MET. TO BRAIN DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death MONTHS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. H76 BLADDER CA.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D10670		29d. DATE SIGNED (Month, Day, Year) 11/9/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Daniel G. Sapir, 10755 Falls Rd., Suite 320, Lutherville, Md. 21093-4582							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

6

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36092

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>MARTHA CRAFT</i>				2. DATE OF DEATH MONTH DAY YEAR <i>November 12 1995</i>				3. TIME OF DEATH <i>11:05 PM</i>			
4. SOCIAL SECURITY NUMBER 223-30-5873				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) December 22, 1911		8. BIRTHPLACE (State or Foreign Country) Natural Bridge, Virginia	
9a. FACILITY NAME (If not institution, give street and number) The Lorien Nursing Center						9b. CITY, TOWN OR LOCATION OF DEATH Columbia				9c. COUNTY OF DEATH Howard County	
RESIDENCE OF DECEDENT											
10a. STATE Maryland			10b. COUNTY Montgomery			10c. CITY, TOWN OR LOCATION Chevy Chase			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 4615 North Park Avenue #102						10f. ZIP CODE 20815			10g. CITIZEN OF WHAT COUNTRY? United States of America		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Junious Combs						18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN					
19a. INFORMANT'S NAME (Type/Print) Mary C. Inoussa (Niece)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4615 North Park Avenue #102, Chevy Chase, MD 20815					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Williams Memorial Park 11/18/95				20c. LOCATION — City or Town, State Roanoke, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE #M00690 <i>Howard A. Carson</i>						22. NAME AND ADDRESS OF FACILITY Hamlar-Curtis Funeral Home 1002 Moorman Road, NW, Roanoke, VA 24016					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Constrictive heart failure</i>											
DUE TO (OR AS A CONSEQUENCE OF):											
b. <i>High blood pressure</i>											
DUE TO (OR AS A CONSEQUENCE OF):											
c. <i>Cardiovascular disease</i>											
DUE TO (OR AS A CONSEQUENCE OF):											
d. <i>Steroid therapy</i>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Bullous Pempfigoid</i>											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard Kolodkusetz</i>						29c. LICENSE NUMBER D31575			29d. DATE SIGNED (Month, Day, Year) 11-13-95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KOLODKUSETZ 9507 Old Annapolis Rd Ellicott City MD 21043											
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOV 11 1951

95 36093

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES EVERETT COATES				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 2, 1995		3. TIME OF DEATH 4:55A M	
4. SOCIAL SECURITY NUMBER 577-56-6862		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS. MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Feb., 15, 1941	
9a. FACILITY NAME (If not institution, give street and number) 6804 Painter Terrace				9b. CITY, TOWN OR LOCATION OF DEATH Capitol Heights		9c. COUNTY OF DEATH Prince George's	
10a. STATE MD		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Capitol Heights		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6804 Painter Terrace				10f. ZIP CODE 20743		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 8th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Janitor		16b. KIND OF BUSINESS/INDUSTRY Private			
17. FATHER'S NAME (First, Middle, Last) Leonard Coates				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Curtis			
19a. INFORMANT'S NAME (Type/Print) Josephine Coates				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6804 Painter Terrace, Capitol Heights, MD 20743			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park 11/6		20c. LOCATION — City or Town, State Landover, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Quawana L. Braxton				22. NAME AND ADDRESS OF FACILITY J. B. Jenkins F. H. 7474 Landover Rd. Landover, MD 20785			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. THROMBOCYTOPENIA AND SEVERE LEUKOCYTOSIS DUE TO (OR AS A CONSEQUENCE OF): c. ELECTROLYTE DISTURBANCE DUE TO (OR AS A CONSEQUENCE OF): d. DIABETES INSIPIDUS							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. DATE OF INJURY (Month, Day, Year)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]		29c. LICENSE NUMBER D42461		29d. DATE SIGNED (Month, Day, Year) 11/2/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. SALIH 5408 SILVERHILL ROAD SUITE 3100 FORESTVILLE, MD							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET 25

NOV 25 1964

ITEMS: 9a,10e, PER NEO FILM G-731 1/22/96 t.t

95 36094

ITEMS: 23 PART I, 27, 28a-f, PER NEO FILM G-730 12/6/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) STERLING DAWN CLARK		2. DATE OF DEATH MONTH DAY YEAR NOV. 01, 1995		3. TIME OF DEATH 19:07 P M	
4. SOCIAL SECURITY NUMBER 578-92-7244		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 32 YRS.	
7. DATE OF BIRTH (Month, Day, Year) DECEMBER 31, 62		8. BIRTHPLACE (State or Foreign Country) VIRGINIA		9a. FACILITY NAME (If not institution, give street and number) ALBERMARLE 107 ALBAMARA ST. APT. 11C	
9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE U.S.A.		10a. STATE MARYLAND	
10b. COUNTY BALTIMORE CO		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER ALBERMARLE 107 ALBAMARA STREET APT. 11C		10f. ZIP CODE 21202		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) LAUNDRY CLERK		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRIVATE	
17. FATHER'S NAME (First, Middle, Last) STERLING W. WALKER		18. MOTHER'S NAME (First, Middle, Maiden Surname) ELMIRA CLARK			
19a. INFORMANT'S NAME (Type/Print) ELMIRA WALKER (MOTHER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5532 KAREN ELAINE DRIVE; NEW CARROLTON, MD 20784			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DINWIDDLE MEMORIAL CEM 11/11/95 PETERSBURG, VIRGINIA		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE GLENDIA M. FREEMAN		22. NAME AND ADDRESS OF FACILITY JOHNSON & JENKINS FUNERAL HOME, INC. 716 KENNEDY STRET. N.W.: WDC 20011			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → COCAINE AND NARCOTIC INTOXICATION					
a. DUE TO (OR AS A CONSEQUENCE OF):					
b. DUE TO (OR AS A CONSEQUENCE OF):					
c. DUE TO (OR AS A CONSEQUENCE OF):					
d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) FOUND: 11-1-95		28b. TIME OF INJURY 7:00 P M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND: RESIDENCE	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 107 ALBAMARA STREET BALTIMORE, MARYLAND		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Moore McKey		29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) NOV. 02, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Moore McKey 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE John A. ...			

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-730 12/6/95 t.t

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SHERON				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 5, 1995				3. TIME OF DEATH 7:17 A.M.	
4. SOCIAL SECURITY NUMBER 579-82-6683		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 32 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/4/63		8. BIRTHPLACE (State or Foreign Country) Wash., D.C.	
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY				9c. COUNTY OF DEATH PRINCE GEORGES	
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY P.G.		10c. CITY, TOWN OR LOCATION Capitol Hgts.				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 128 Daimler Drive				10f. ZIP CODE 20743		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE - American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) Unemployed				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed				16b. KIND OF BUSINESS/INDUSTRY None	
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Cobb					
19a. INFORMANT'S NAME (Type/Print) Jannie R. Cobb				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Nat'l. Mem. Park				20c. LOCATION - City or Town, State Laurel, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Danny H. Pratt				22. NAME AND ADDRESS OF FACILITY H.S. Washington & Sons, inc. 4925 Burroughs Ave., N.E.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE DESIPRAMINE INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) FOUND 11-5-95		28b. TIME OF FOUNDING 6:00 A.M.		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURED SUBJECT INGESTED DRUG				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 128 DAIMLER DRIVE CAPITOL HEIGHTS, MD.	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute MD					
				29c. LICENSE NUMBER O.C.M.E.				29d. DATE SIGNED (Month, Day, Year) NOVEMBER 6, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DENNIS CHUTE 111 Penn Street, Baltimore, Maryland 21201									
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36096

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charlotte S. Cobban				2. DATE OF DEATH MONTH DAY YEAR Nov 2, 1995		3. TIME OF DEATH 5:55 AM M	
4. SOCIAL SECURITY NUMBER 104 32 7726		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 6, 1901	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) Manor Care Nursing Home Largo		9b. CITY, TOWN OR LOCATION OF DEATH Largo	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Bowie				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 11103 Fruitwood Drive	
10f. ZIP CODE 20720				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Robert R. Starck				18. MOTHER'S NAME (First, Middle, Maiden Surname) Charlotte K. Koch			
19a. INFORMANT'S NAME (Type/Print) Karen Lee Walsh				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11103 Fruitwood Drive Bowie Maryland 20720			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 11/3/95		20c. LOCATION — City or Town, State Alexandria Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres				22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis b. Megacolon c. d. Approximate interval Between Onset and Death Days Months Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Breast Cancer							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Breast Cancer							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER MD				29c. LICENSE NUMBER D32261		29d. DATE SIGNED (Month, Day, Year) 11-2-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard J. Feldman MD 9500 Annapolis Rd, Chantilly MD 20706							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE John Andrew Radell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARUNKNOWN 95-278
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JERALD RAY COWGILL				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 4 1995		3. TIME OF DEATH 04:30A M					
4. SOCIAL SECURITY NUMBER 220-96-5170		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 31 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 6, 1964		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not Institution, give street and number) PENNSYLVANIA AVE/WOODYARD RD				9b. CITY, TOWN OR LOCATION OF DEATH Mellwood				9c. COUNTY OF DEATH PRINCE GEORGES			
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Mount Rainier				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 4002 37th Street				10f. ZIP CODE 20712		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sheet Metal Mechanic		16b. KIND OF BUSINESS/INDUSTRY Construction							
17. FATHER'S NAME (First, Middle, Last) William H. Cowgill, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Vivian E. Keller							
19a. INFORMANT'S NAME (Type/Print) William H. Cowgill III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8505 Cunningham Drive, College Park, MD 20740							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 11/8/95		DATE 11/8/95		20c. LOCATION — City or Town, State Brentwood, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis Gasch</i>		22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Head Injury</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year) 10/4/95		28b. TIME OF INJURY 3:17A M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED <i>subject drove, struck trees and ejected</i>			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) roadway				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Pennsylvania Avenue in Upper Marlboro Prince Georges, Maryland					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 4 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Hardell</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36098

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

12 1/11

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <i>Patricia Ann Calhoun</i>				2. DATE OF DEATH MONTH <i>November</i> DAY <i>8</i> YEAR <i>1995</i>				3. TIME OF DEATH <i>9:30 A</i>	
4. SOCIAL SECURITY NUMBER <i>277-40-2841</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>52</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan. 23 1943</i>		8. BIRTHPLACE (State or Foreign Country) <i>Washington, DC</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>4119 Branch Avenue</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Marlow Heights, MD</i>				9c. COUNTY OF DEATH <i>Prince Georges</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Prince Georges</i>		10c. CITY, TOWN OR LOCATION <i>Forestville, Maryland</i>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>5509 Marlboro Pike #8</i>		10f. ZIP CODE <i>20747</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Lithographer</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Federal Government</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Nimrod Johnson</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Clara Shetterly</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Christopher Calhoun (Son)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5509 Marlboro Pike #8 Forestville, MD. 20747</i>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) <i>Washington National</i>		OATE <i>11/15</i>		20c. LOCATION — City or Town, State <i>Suitland, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex S. Pope Jr.</i>				22. NAME AND ADDRESS OF FACILITY <i>Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD 20747</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Chronic obstructive pulmonary disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Automobile</i>							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <i>N/A</i>		28b. TIME OF INJURY <i>N/A</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>N/A</i>	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>N/A</i>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>N/A</i>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>						29c. LICENSE NUMBER <i>D21230</i>		29d. DATE SIGNED (Month, Day, Year) <i>November 8, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez M.D. 5009 Rayburn Ct., Camp Springs, MD 20748</i>									
31. DATE FILED (Month, Day, Year) <i>NOV 14 1995</i>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2011-2012

95 36099

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) J. HORNSBY DRAYTON				2. DATE OF DEATH MONTH November DAY 11, YEAR 1995				3. TIME OF DEATH 9:30 AM M					
4. SOCIAL SECURITY NUMBER 255-01-2809		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan. 8, 1909		8. BIRTHPLACE (State or Foreign Country) Georgia		
9a. FACILITY NAME (If not institution, give street and number) Springbrook Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery					
RESIDENCE OF DECEDENT													
10a. STATE MD		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 14131 Cricket Lane				10f. ZIP CODE 20904				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk				16b. KIND OF BUSINESS/INDUSTRY Candy Company					
17. FATHER'S NAME (First, Middle, Last) Unobtainable						18. MOTHER'S NAME (First, Middle, Maiden Surname) Unobtainable							
19a. INFORMANT'S NAME (Type/Print) Patricia L. Foster						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14131 Cricket Lane, Silver Spring, MD 20904							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Walker Memorial Park 11/14/95		DATE		20c. LOCATION — City or Town, State Augusta, GA					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Luci Kent-Hill</i>				22. NAME AND ADDRESS OF FACILITY 1800 New Hampshire Ave Silver Spring, MD 20904									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Terminal Metastatic Cancer DUE TO (OR AS A CONSEQUENCE OF): b. Carcinoma Lung, Liver and Bone DUE TO (OR AS A CONSEQUENCE OF): c. Old Age DUE TO (OR AS A CONSEQUENCE OF): d. Arteriosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Maneywala</i>				29c. LICENSE NUMBER D13677		29d. DATE SIGNED (Month, Day, Year) 11-13-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B G Maneywala, MS 14201 Laurel Park Dr Laurel MD 20707													
31. DATE FILED (Month, Day, Year) NOV 15 1995				32. REGISTRAR'S SIGNATURE <i>Julia Swisher Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36100

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Antonio DiBella				2. DATE OF DEATH MONTH DAY YEAR November 8 1995		3. TIME OF DEATH 1:10 P M	
4. SOCIAL SECURITY NUMBER 579-28-4498		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 22, 1902	
9a. FACILITY NAME (If not institution, give street and number) Springbrook Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE N/A				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Washington, D.C.	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 5766 Sherrier Place			
10f. ZIP CODE 20016				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Barber		16b. KIND OF BUSINESS/INDUSTRY Self-Employed			
17. FATHER'S NAME (First, Middle, Last) Joseph A. DiBella				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Abate			
19a. INFORMANT'S NAME (Type/Print) Joan Ellen DiBella				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1109 Dryden Street, Silver Spring, MD 20901			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 11/9/95		20c. DATE 11/9/95		20d. LOCATION — City or Town, State Alexandria, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John L. Chipak				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 20901 500 University Boulevard, W. Sil. Spr. MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Dehydration DUE TO (OR AS A CONSEQUENCE OF): c. Dementia DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death 2 weeks 1 month 10 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Paul Armstrong				29c. LICENSE NUMBER 043237		29d. DATE SIGNED (Month, Day, Year) 11/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4201 Laurel Pk. Dr. #102 Laurel, MD 20707 Paul Armstrong							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE Julia Anderson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36101

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mary E. Dant</i>				2. DATE OF DEATH MONTH DAY YEAR <i>November 16, 1995</i>				3. TIME OF DEATH <i>5:06 A M</i>			
4. SOCIAL SECURITY NUMBER <i>577-32-9942</i>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>75</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 31, 1920</i>		8. BIRTHPLACE (State or Foreign Country) <i>Arkansas</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Charles County Nursing Home</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>La Plata</i>			9c. COUNTY OF DEATH <i>Charles</i>		
10a. STATE <i>Maryland</i>						10b. COUNTY <i>Charles</i>			10c. CITY, TOWN OR LOCATION <i>La Plata</i>		
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						10e. STREET AND NUMBER <i>Route 488 - CCNH</i>			10f. ZIP CODE <i>20646</i>		
10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>						11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:						14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i>College</i>		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Clerk</i>						16b. KIND OF BUSINESS/INDUSTRY <i>Census Bureau</i>			17. FATHER'S NAME (First, Middle, Last) <i>Horace Lee Dennis</i>		
18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Birdie Mildred Nash</i>						19a. INFORMANT'S NAME (Type/Print) <i>Judy Dant</i>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3209 Westdale Court, Waldorf, MD 20601</i>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Cedar Hill Cemetery</i>				DATE <i>11-20</i>		20c. LOCATION — City or Town, State <i>Suitland, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Benjamin M. Matthews</i>				22. NAME AND ADDRESS OF FACILITY <i>Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic Heart Disease</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Hypertension</i> <i>Cerebrovascular accident</i> <i>Arteriosclerosis</i>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypercholesterolemia, Esophagitis, Osteoarthritis, pancreatitis, Renal failure</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>James Patrick Hunt</i>				29c. LICENSE NUMBER <i>D08370</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/16/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>P.O. Box 1317, 118 LA GRANGE AVE, LA PLATA, MD 20646</i>											
31. DATE FILED (Month, Day, Year) <i>NOV 17 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 36102

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BERNARD DORSEY				2. DATE OF DEATH MONTH DAY YEAR 11 06 1995		3. TIME OF DEATH 5:30A M	
4. SOCIAL SECURITY NUMBER 220-28-7298		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03 25 1932	
8. BIRTHPLACE (State or Foreign Country) D.C.				9. FACILITY NAME (If not institution, give street and number) Greenbelt Nursing Center		10. CITY, TOWN OR LOCATION OF DEATH Greenbelt	
11. RESIDENCE OF DECEDENT 10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bowie	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 13117-7th Street		10f. ZIP CODE 20719	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Porter	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Private				16a. KIND OF BUSINESS/INDUSTRY Private		17. FATHER'S NAME (First, Middle, Last) Carrole Dorsey	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Dolly Brooks				19a. INFORMANT'S NAME (Type/Print) Monroe Dorsey/Brother		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11812 Duckettown Road, Bowie, MD 20719	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 11/09/1995 Brentwood, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wuwan D. Braxton</i>				22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 20785 7474 Landover Rd. Landover, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cancer of Esophagus							
DUE TO (OR AS A CONSEQUENCE OF): Pleural Effusion							
DUE TO (OR AS A CONSEQUENCE OF): Valvular Heart Disease							
DUE TO (OR AS A CONSEQUENCE OF): Alcohol Abuse							
Approximate Interval Between Onset and Death Two yrs. 1 month 10+ yrs 30+ yrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Smoker.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R Gupta MD</i>				29c. LICENSE NUMBER D20727		29d. DATE SIGNED (Month, Day, Year) 11-7-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RENUKA GUPTA 7215 D HANOVER PARKWAY GREENBELT MD 20720							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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NOV 1957

95 36103

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARION DREHER				2. DATE OF DEATH OCTOBER 31, 1995		3. TIME OF DEATH 1:33PM	
4. SOCIAL SECURITY NUMBER 579 26 0867		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 25 1924	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bowie		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3505 Morlock Lane				10f. ZIP CODE 20715		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Robert M. Sigwald				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna B. Smith			
19a. INFORMANT'S NAME (Type/Print) Laura Ann Lockwood				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2910 Nemeth Lane Bowie Maryland 20715			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 11/2/95		20c. LOCATION — City or Town, State Alexandria Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans, Pres.				22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		e. SEPTIC SHOCK					Approximate Interval Between Onset and Death 1 DAY
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. IMMUNE DEFICIENCY					3 YEARS
		c. RHEUMATOID ARTHRITIS					30 YEARS
		d. HIP PROSTHESIS FRACTURE					1 WEEK
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS, PNEUMONIA DISEASE, AORTIC STENOSIS						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Norman K. Bohrer MD				29c. LICENSE NUMBER D00574		29d. DATE SIGNED (Month, Day, Year) Nov 1, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Norman K. Bohrer MD 3231 SUPERIOR LANE BOWIE, MD 20715							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE John Shuster-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36104

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Pearl M. Doyle</i>				2. DATE OF DEATH MONTH DAY YEAR <i>11 7 95</i>		3. TIME OF DEATH <i>345 P M</i>	
4. SOCIAL SECURITY NUMBER <i>187 16 2152</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>93</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 10, 1902</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>				9a. FACILITY NAME (If not Institution, give street and number) <i>Crofton Convalescent Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Crofton</i>	
9c. COUNTY OF DEATH <i>Anne Arundel</i>				10a. STATE <i>Pennsylvania</i>		10b. COUNTY <i>Schuylkill</i>	
10c. CITY, TOWN OR LOCATION <i>Branchdale</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>Pine Street</i>	
10f. ZIP CODE <i>27923</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Seamstress</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Factory Minersville Dress Manufacturer</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Mathew Henry Petrea</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Catherine (Unknown)</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Jean Doyle Irvin</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1653 Crofton Parkway Crofton Maryland 21114</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Mary's Star of the Sea Catholic Church Cemetery</i>			
20c. LOCATION — City or Town, State <i>Llewellyn Pa.</i>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Evans Pres.</i>			
22. NAME AND ADDRESS OF FACILITY <i>Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory Failure</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Pneumonia</i> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Asthma</i>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <i>11/7/95</i>			
28b. TIME OF INJURY <i>M</i>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George Cavanaugh</i>				29c. LICENSE NUMBER <i>1731602</i>			
29d. DATE SIGNED (Month, Day, Year) <i>11/7/95</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>George Cavanaugh 1655 Crofton Blvd. #013 Crofton Md. 21114</i>			
31. DATE FILED (Month, Day, Year) <i>NOV 13 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSALEA VIRGINIA DIVEBLISS				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 21 1995		3. TIME OF DEATH 10:14 A M	
4. SOCIAL SECURITY NUMBER 233-34-3314		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) January 26, 1926	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
10a. STATE MD		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hancock		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 214 Myers Street				10f. ZIP CODE 21750		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 6 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Harry Vanorsdale				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Shepherd			
19a. INFORMANT'S NAME (Type/Print) Lloyd Divebliss				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 Myers Street Hancock, MD 21750			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Lawn Mem. Pk 11/24/95		20c. LOCATION — City or Town, State Hagerstown, MD 21740			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY Grove Funeral Home P.O. Box 368 Hancock, MD 21750					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE cause (Final disease or condition resulting in death) → Severe Chronic obstructive pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure Disorder, Peptic ulcer Disease, Congestive Heart Failure							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 021457		29d. DATE SIGNED (Month, Day, Year) 11/23/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ABOUL WATHEAD, MD - 12821 - OAK HILL AVE. HAGERSTOWN, MD							
31. DATE FILED (Month, Day, Year) NOV 29 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


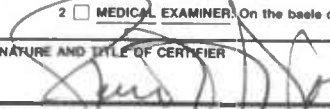
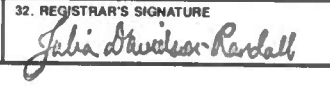
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36106

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lagatha Perry Erickson				2. DATE OF DEATH MONTH DAY YEAR November 14, 1995		3. TIME OF DEATH 8:00 pm	
4. SOCIAL SECURITY NUMBER 577-42-9938		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 25, 1916	
8a. FACILITY NAME (If not institution, give street and number) Carriage Hill Bethesda				8b. CITY, TOWN OR LOCATION OF DEATH Bethesda		8c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1320 Midwood Place				10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrative Assistant		16b. KIND OF BUSINESS/INDUSTRY Federal Government			
17. FATHER'S NAME (First, Middle, Last) William Perry				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Adams			
19a. INFORMANT'S NAME (Type/Print) John H. Erickson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Mercer Court Sterling, Virginia 20165			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park November 18, 1995		20c. LOCATION — City or Town, State Rockville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00335				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Stroke DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death 2 Weeks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Respiratory Failure, Pneumonia Chronic Obstructive Pulmonary Disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D07471		29d. DATE SIGNED (Month, Day, Year) November 16, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul T. Noone, M.D. 50 West Edmonston Drive #207, Rockville, Maryland 20852							
31. DATE FILED (Month, Day, Year) NOV 17 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



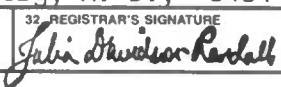
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36107

ITEM: 4. PER INFORMANT FILM G-743 1/13/97 t.t

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruth S. Eaton				2. DATE OF DEATH MONTH DAY YEAR November 10, 1995		3. TIME OF DEATH 1:30 P M	
4. SOCIAL SECURITY NUMBER 085-12-5850 092-12-3384		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 24, 1922	
9a. FACILITY NAME (If not institution, give street and number) 4620 North Park Avenue, #1003-E				9b. CITY, TOWN OR LOCATION OF DEATH Chevy Chase		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Chevy Chase		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4620 North Park Avenue #1003-E				10f. ZIP CODE 20815		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) J. D. Shear				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Tichenor			
19a. INFORMANT'S NAME (Type/Print) Martha Batsel (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9404 Lakeside Dr, Vienna, VA 22182			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory		DATE 11-11		20c. LOCATION — City or Town, State Beltsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic cancer of the brain DUE TO (OR AS A CONSEQUENCE OF): b. Oat Cell cancer of lung DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER #10205		29d. DATE SIGNED (Month, Day, Year) November 10, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stanley M. Silverberg, M. D., 5454 Wisconsin Avenue, #925, Chevy Chase, MD 20815							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

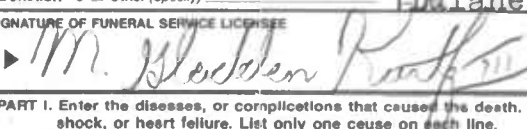
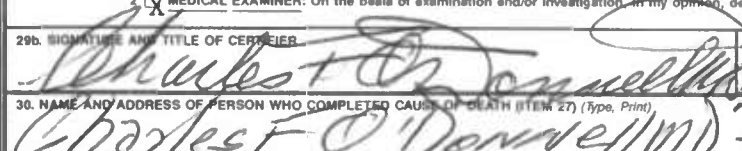
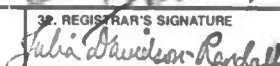
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6 95 36108

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth A ECKER Evans				2. DATE OF DEATH MONTH DAY YEAR Nov 7 1995		3. TIME OF DEATH 12:54 A M				
4. SOCIAL SECURITY NUMBER 219-10-8981		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/22/1925		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Towson			9c. COUNTY OF DEATH Baltimore			
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Glen Arm			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 11444 Glen Arm Road				10f. ZIP CODE 21057		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 13 College (1-4 or 5+) - -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY Banking						
17. FATHER'S NAME (First, Middle, Last) Howard Franklin Ecker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Elizabeth Gone						
19a. INFORMANT'S NAME (Type/Print) C. Calvin Evans				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Gar. 11/10 Timonium, Maryland		DATE 11/10		20c. LOCATION — City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Kurtz Funeral Home Jarrettsville, Maryland						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Embolism DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Hemothorax, left side DUE TO (OR AS A CONSEQUENCE OF): c. with focal hematoma left lung DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple rib fractures							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Family permission		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) Oct 23, 1995		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Fall		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 09383		29d. DATE SIGNED (Month, Day, Year) 11-10-95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles F. O'Donnell (M) - 111 Hamlet Hill Rd Baltimore										
31. DATE FILED (Month, Day, Year) NOV 14 1995		32. REGISTRAR'S SIGNATURE 								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELWOOD THOMAS ENNIS				2. DATE OF DEATH MONTH DAY YEAR NOV. 04, 1995		3. TIME OF DEATH 6:00 PM							
4. SOCIAL SECURITY NUMBER 577-32-6355		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 18, 1916		8. BIRTHPLACE (State or Foreign Country) Virginia					
9a. FACILITY NAME (If not institution, give street and number) 2612 ROSS RD.				9b. CITY, TOWN OR LOCATION OF DEATH Chevy Chase			9c. COUNTY OF DEATH MONTGOMERY						
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Chevy Chase			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						
10e. STREET AND NUMBER 2612 Ross Road				10f. ZIP CODE 20815		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 2 <input type="checkbox"/> Married 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Floor Finisher		16b. KIND OF BUSINESS/INDUSTRY Construction									
17. FATHER'S NAME (First, Middle, Last) Luther Ennis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva Heflin									
19a. INFORMANT'S NAME (Type/Print) Katherine M. Winter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4905 66th Avenue, Hyattsville, Maryland 20784									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 11/9/95		20c. LOCATION — City or Town, State Arlington, Virginia									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis Gasch</i>		22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>George H. K... OCME</i>								29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) NOV. 05, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE McK... 111 Penn Street, Baltimore, Maryland 21201													
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>John A. Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDDIE Winston Carl EDWARDS				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 6 - 1995		3. TIME OF DEATH 21 30 P M	
4. SOCIAL SECURITY NUMBER 451-18-8591		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 27, 1917	
8. BIRTHPLACE (State or Foreign Country) Alexandria, LA				9. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital		10. CITY, TOWN OR LOCATION OF DEATH Clinton	
11. RESIDENCE OF DECEDENT 5430 Chicamuxen Road				12. STATE Maryland		13. COUNTY Charles	
14. CITY, TOWN OR LOCATION Indian Head				15. INSIDE CITY LIMITS? 1 X YES 2 NO		16. CITIZEN OF WHAT COUNTRY? United States	
17. ZIP CODE 20640				18. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO	
20. RACE — American Indian, Black, White, etc. Specify: Black				21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12)		22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance Engineer	
23. KIND OF BUSINESS/INDUSTRY D. C. Government				24. FATHER'S NAME (First, Middle, Last) Robert Edwards		25. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Fox	
26. INFORMANT'S NAME (Type/Print) Melba F. Edwards				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5430 Chicamuxen Road, Indian Head, Maryland 20640			
28. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State				29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 11/11/95 Brentwood, Maryland			
30. SIGNATURE OF FUNERAL SERVICE LICENSEE John T. Stewart III				31. NAME AND ADDRESS OF FACILITY STEWART FUNERAL HOME 4001 Benning Road, N.E., Washington, D. C.			
32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute myocardial infarction Chronic renal failure EDDM Peripheral Arterial disease							
33. IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
34. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
36. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
37. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO				38. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA			
39. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide				40. DATE OF INJURY (Month, Day, Year) 11/7/95			
41. TIME OF INJURY M				42. INJURY AT WORK? 1 YES 2 NO			
43. DESCRIBE NOW INJURY OCCURRED				44. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
45. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
46. SIGNATURE AND TITLE OF CERTIFIER Dr. [Signature] MD Attending							
47. LICENSE NUMBER D-24535							
48. DATE SIGNED (Month, Day, Year) 11/7/95							
49. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LAXMI BEAWA 7700 OLD BRANCH AVENUE CLINTON MARYLAND 20755							
50. DATE FILED (Month, Day, Year) NOV 15 1995							
51. REGISTRAR'S SIGNATURE John [Signature]							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text at the bottom of the page, possibly a signature or date.

95 36111

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Molly Freishtat				2. DATE OF DEATH MONTH 11 DAY 11 YEAR 95		3. TIME OF DEATH 0200 M	
4. SOCIAL SECURITY NUMBER 214-52-2995		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 91 YRS.	7. DATE OF BIRTH (Month, Day, Year) May 15, 1904		8. BIRTHPLACE (State or Foreign Country) Russia	
9a. FACILITY NAME (If not institution, give street and number) 1801 E. Jefferson St, Apt. 411				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
10a. STATE Md.				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 1801 E. Jefferson St. Apt. 411				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Homemaker			
17. FATHER'S NAME (First, Middle, Last) Samuel Portnoy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jenny Unknown			
19a. INFORMANT'S NAME (Type/Print) David Freishtat				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12837 Lamp Post Lane Rockville MD 20854			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Lebanon Cemetery 11/13		20c. LOCATION — City or Town, State Adelphi, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC ARREST</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>ARRHYTHMIA</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>MYOPERIKSION</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>DIABETES MELLITUS, TYPE II</u> Approximate Interval Between Onset and Death 2 yrs.							Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER MP37096		29d. DATE SIGNED (Month, Day, Year) 11/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8700 GEORGIA AVE SILVER SPRING, MD 20910							
31. DATE FILED (Month, Day, Year) NOV 14 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36112

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA E. FRIEDMAN				2. DATE OF DEATH MONTH NOVEMBER DAY 14, 1995 YEAR		3. TIME OF DEATH 7:05 AM	
4. SOCIAL SECURITY NUMBER 064-05-7438		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	7. DATE OF BIRTH (Month, Day, Year) JULY 5, 1908		8. BIRTHPLACE (State or Foreign Country) RUSSIA	
9a. FACILITY NAME (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON				9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11427 FAIROAK DRIVE				10f. ZIP CODE 20902		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FLOWER DESIGNER		16b. KIND OF BUSINESS/INDUSTRY ARTIFICIAL FLORAL ARRANGEMENTS			
17. FATHER'S NAME (First, Middle, Last) JACOB ZASH				18. MOTHER'S NAME (First, Middle, Maiden Surname) DORA NOVAK			
19a. INFORMANT'S NAME (Type/Print) ELAINE GEDANKEN (DAUGHTER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11427 FAIROAK DRIVE-SILVER SPRING, MARYLAND 20902			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ARARAT CEMETERY		20c. LOCATION — City or Town, State 11/16 E. FARMINGDALE, NEW YORK			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC ANEMIA DUE TO (OR AS A CONSEQUENCE OF): b. GAUCHER'S DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D. Attending Physician				29c. LICENSE NUMBER D 18084		29d. DATE SIGNED (Month, Day, Year) NOV. 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D.D. PATEL, M.D. 612, MONTROSE RD, ROCKVILLE, MD 20852							
31. DATE FILED (Month, Day, Year) NOV 15 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

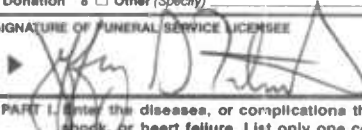


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Everett G. Fuller		2. DATE OF DEATH MONTH DAY YEAR November 15, 1995		3. TIME OF DEATH 9:18 A M	
4. SOCIAL SECURITY NUMBER 145-16-8277	5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	7. DATE OF BIRTH (Month, Day, Year) Dec. 6, 1920	8. BIRTHPLACE (State or Foreign Country) Massachusetts	
9a. FACILITY NAME (If not institution, give street and number) Wilson Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT					
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Bethesda		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9016 Honeybee Lane		10f. ZIP CODE 20817	10g. CITIZEN OF WHAT COUNTRY? United States		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) — 5+ Physicist			
16. KIND OF BUSINESS/INDUSTRY National Bureau of Standards		17. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Physicist			
18. FATHER'S NAME (First, Middle, Last) Everett Webb Fuller		19. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Laura Gladding			
19a. INFORMANT'S NAME (Type/Print) Gladys H. Fuller		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9016 Honeybee Lane, Bethesda, Maryland 20817			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) November 16, 1995 Montgomery Crematorium, Inc.		20c. LOCATION — City or Town, State Bethesda, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00689		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death Minutes	
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Atherosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF):		Years	
		c. DUE TO (OR AS A CONSEQUENCE OF):			
		d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER 033357		29d. DATE SIGNED (Month, Day, Year) November 16, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lee Jonathan Musher 5530 Wisconsin Ave Chevy Chase MD 20812					
31. DATE FILED (Month, Day, Year) NOV 17 1995		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended Harford County Health Dept. 11/16/95 KDG
Line # 16&16B

95 36114

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) RICHARD ALLEN FLUHARTY				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 6 1995		3. TIME OF DEATH 10:59 P	
4. SOCIAL SECURITY NUMBER 279-40-9599		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 56 YRS.	7. DATE OF BIRTH (Month, Day, Year) April 13, 1939		8. BIRTHPLACE (State or Foreign Country) Ohio	
9a. FACILITY NAME (If not institution, give street and number) HARFORD MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH HAVRE de GRACE		9c. COUNTY OF DEATH HARFORD	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Aberdeen		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 30 Liberty Street				10f. ZIP CODE 21001		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Vietnam		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Adhesive Mixer Operator		16b. KIND OF BUSINESS/INDUSTRY Manufacturing Construction	
17. FATHER'S NAME (First, Middle, Last) Ray Okey Fluharty				18. MOTHER'S NAME (First, Middle, Maiden Surname) Izetta (nmn) Monroe			
19a. INFORMANT'S NAME (Type/Print) Sue E. Fluharty				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Liberty Street, Aberdeen, Maryland 21001			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ebenezer UMC Cemetery 11-11-95		20c. LOCATION — City or Town, State Roseville, Ohio			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY McComas Funeral Home 1317 Cokesbury Road, Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <i>Inspection</i>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 07, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HAROLD A. KOREL MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36115

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LLOYD GIDDINGS				2. DATE OF DEATH MONTH NOVEMBER DAY 8 , YEAR 1995		3. TIME OF DEATH 5:45 A M	
4. SOCIAL SECURITY NUMBER 213-56-9925		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 14, 1948	
8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) Prince Georges Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince Georges	
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Landover		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 7761 Greymount Street				10f. ZIP CODE 20785		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 10th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) Lloyd Giddings, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Smith			
19a. INFORMANT'S NAME (Type/Print) Barbara Pearson (Sister)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11733 Laurel Drive, Laurel, MD 20708			
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ash Memorial Cem. 11/14		20c. LOCATION — City or Town, State Sandy Spring, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Esophageal Carcinoma DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 X Natural 5 Pending Investigation 2 Accident 8 Could not be determined 3 Suicide 4 Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>E. S. Holland, MD</i>				29c. LICENSE NUMBER D 20989		29d. DATE SIGNED (Month, Day, Year) 11/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edward S. Holland, MD, 6492 Landover Rd, Cheverly, MD 20785							
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36116

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Tomasello, John Giovanni</i>				2. DATE OF DEATH MONTH DAY YEAR November 10, 1995		3. TIME OF DEATH 12:38 A M	
4. SOCIAL SECURITY NUMBER 579-50-0246		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 22, 1937	
8. BIRTHPLACE (State or Foreign Country) Italy				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5824 Lenox Road	
10f. ZIP CODE 20817				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner				16b. KIND OF BUSINESS/INDUSTRY Restaurant			
17. FATHER'S NAME (First, Middle, Last) Salvatore Tomasello				18. MOTHER'S NAME (First, Middle, Maiden Surname) Barbara M. Messina			
19a. INFORMANT'S NAME (Type/Print) Olga Tomasello				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5824 Lenox Street, Bethesda, Maryland 20817			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 11/13			
20c. LOCATION — City or Town, State Silver Spring, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shirley D. Knall</i>			
22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Non Hodgkins Lymphoma</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Shirley D. Knall</i>			
29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) 11/10/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LLOYD HEPBURN MD 104 N. Capitol Wash D.C. 20002							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8117

95 36117

ITEM: 19b, PER F.H. FILM G-729 11/30/95 t.t

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Louise Green				2. DATE OF DEATH MONTH Nov. DAY 18, YEAR 1995		3. TIME OF DEATH 5:04 P M	
4. SOCIAL SECURITY NUMBER 220-52-3288		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 23, 1907	
9a. FACILITY NAME (If not institution, give street and number) 3963 Baptist Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Taneytown		9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Taneytown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3963 Baptist Rd.				10f. ZIP CODE 21787		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) John Simonson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rhoda Hymiller			
19a. INFORMANT'S NAME (Type/Print) Connie Bailey				19b. MAILING ADDRESS 1501 WAREHIME RD. City or Town, State, Zip Code 105 Warfieldsborg Rd., Westminster, MD 21157 21158			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadow Branch Cemetery 11/22/95		20c. LOCATION — City or Town, State Westminster, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katherine Pitts-Switzer				22. NAME AND ADDRESS OF FACILITY Pitts Funeral Home & Chapel 412 Washington Rd., Westminster, MD 21157			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute pulmonary edema DUE TO (OR AS A CONSEQUENCE OF): b. Coronary disease DUE TO (OR AS A CONSEQUENCE OF): c. — DUE TO (OR AS A CONSEQUENCE OF): d. — Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John Simonson				29c. LICENSE NUMBER D20330		29d. DATE SIGNED (Month, Day, Year) 11/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Simonson, 104 N. Main St., Union Bridge, MD 21784							
31. DATE FILED (Month, Day, Year) NOV 20 1995				32. REGISTRAR'S SIGNATURE John Simonson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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18
95 361181 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Alice Gatchell				2. DATE OF DEATH MONTH DAY YEAR November 7, 1995				3. TIME OF DEATH 9:05P M							
4. SOCIAL SECURITY NUMBER 212-30-2391		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-04-1934		8. BIRTHPLACE (State or Foreign Country) WV							
9a. FACILITY NAME (If not institution, give street and number) 1433 Perryville Road				9b. CITY, TOWN OR LOCATION OF DEATH Perryville				9c. COUNTY OF DEATH Cecil							
10a. STATE MD		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Perryville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 1433 Perryville Road				10f. ZIP CODE 21903		10g. CITIZEN OF WHAT COUNTRY? USA									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home											
17. FATHER'S NAME (First, Middle, Last) Carl Metz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma											
19a. INFORMANT'S NAME (Type/Print) Mr. Robert Gatchell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1433 Perryville Road, Perryville, MD 21903											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Angel Hill Cemetery 11/10		20c. LOCATION — City or Town, State Havre de Grace, MD											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William S. Smith</i>				22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma Lung Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 18 months															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD, Coronary Artery Disease								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>William S. Smith MD</i>										29c. LICENSE NUMBER D32609		29d. DATE SIGNED (Month, Day, Year) November 8, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kamrudin Mithani, M.D., 703 Revolution St., Havre de Grace, MD 21078														939-1050	
31. DATE FILED (Month, Day, Year) NOV 9 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

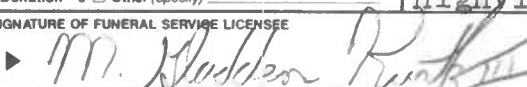
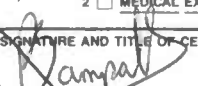
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH		REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) BERNICE SYLVIA GRICE						2. DATE OF DEATH MONTH NOV. DAY 08 YEAR 95		3. TIME OF DEATH 10:55 A.M.		
4. SOCIAL SECURITY NUMBER 235-22-7217		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08-10-1921		8. BIRTHPLACE (State or Foreign Country) MD		
9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace			9c. COUNTY OF DEATH Harford			
RESIDENCE OF DECEDENT										
10a. STATE MD		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Havre de Grace				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 128 Deaver Street				10f. ZIP CODE 21078			10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) George Ervin					18. MOTHER'S NAME (First, Middle, Maiden Surname) Virgie McRobie					
19a. INFORMANT'S NAME (Type/Print) Mr. David W. Grice					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 Deaver St., Havre de Grace, MD 21078					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) R. A. Ferris & Co, Inc 11/9			20c. LOCATION — City or Town, State West Chester, PA				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Anterior Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): c. Cardiogenic Shock DUE TO (OR AS A CONSEQUENCE OF): d. Diabetes Approximate Interval Between Onset and Death 3 Hours										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO										
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
			28d. DESCRIBE HOW INJURY OCCURRED			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Vivek Varma					29c. LICENSE NUMBER D35832		29d. DATE SIGNED (Month, Day, Year) NOV/08/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VIVEK VARMA, MD 508 GIRARD STREET, HAVRE DE GRACE MD 21078										
31. DATE FILED NOV 9 1995			32. REGISTRAR'S SIGNATURE 							

95 36120

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Mason Green				2. DATE OF DEATH MONTH November DAY 6 , 1995 YEAR				3. TIME OF DEATH 10:49 p.m.	
4. SOCIAL SECURITY NUMBER 139-14-0475		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/31/1919		8. BIRTHPLACE (State or Foreign Country) Massachusetts	
9a. FACILITY NAME (If not institution, give street and number) Bayview Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH -	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Jarrettsville				10d. INSIDE CITY LIMITS? 1 YES 2 X NO	
10e. STREET AND NUMBER 3517 North Furnace Road				10f. ZIP CODE 21084		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Major		16b. KIND OF BUSINESS/INDUSTRY United States Army			
17. FATHER'S NAME (First, Middle, Last) Raymond John Green Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Maude Whitehead					
19a. INFORMANT'S NAME (Type/Print) Dorothea M. Green				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10					
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Highview Mem. Garden 11/9		DATE Fallston, Maryland		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Kurtz Funeral Home Jarrettsville, Maryland					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Increased intracranial pressure DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Ventricular arrhythmia DUE TO (OR AS A CONSEQUENCE OF): closed head injury DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								Approximate interval Between Onset and Death 2 days	
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. MANNER OF DEATH 1 Natural 5 Pending investigation 2 X Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. DATE OF INJURY (Month, Day, Year) 11-04-95		28b. TIME OF INJURY unknown M		28c. INJURY AT WORK? 1 YES 2 X NO		28d. DESCRIBE HOW INJURY OCCURRED fell down steps	
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) home				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8517 N. Furnace Rd. 21084					
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER:  PRAKASH SAMPATH				29c. LICENSE NUMBER L3686		29d. DATE SIGNED (Month, Day, Year) 11/6/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Johns Hopkins Bayview Medical Center 4940 Eastern Avenue, Baltimore, MD 21224									
31. DATE FILED (Month, Day, Year) NOV 14 1995									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released on Approval by Medical Examiner
DIVISION OF VITAL RECORDS, P.O. BOX 6876
BALTIMORE, MARYLAND 21215-0020TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) REBECCA GOINS				2. DATE OF DEATH MONTH DAY YEAR Nov 15 1995		3. TIME OF DEATH 4 40 P.M.	
4. SOCIAL SECURITY NUMBER 213-46-7198		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 11, 1906	
9a. FACILITY NAME (If not institution, give street and number) Mariner Health Care of Laurel				9b. CITY, TOWN OR LOCATION OF DEATH Laurel		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Laurel	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 14200 Laurel Park Drive				10f. ZIP CODE 20707		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO If YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 8 Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) George W. Bennett				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Jane Hill			
19a. INFORMANT'S NAME (Type/Print) B. Mae Blevins Charlie O. Goins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6404 Seabrook Road Lanham, Maryland 20706			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Goins Cemetery 11/20/1995		20c. LOCATION — City or Town, State Whitley, Kentucky			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles F. Ball</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Organ Brain Syndrome DUE TO (OR AS A CONSEQUENCE OF): Sequitally flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 3 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Andrew K... ..</i>				29c. LICENSE NUMBER 1136716		29d. DATE SIGNED (Month, Day, Year) 11-15-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Andrew K... .. 8317 CHERRY LAKE LAUREL, MD 20707							
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 36122

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Juan Jose Garcia				2. DATE OF DEATH MONTH DAY YEAR November 8, 1995		3. TIME OF DEATH 1:20 a m	
4. SOCIAL SECURITY NUMBER 213-15-2172		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 23, 1959	
8. BIRTHPLACE (State or Foreign Country) El Salvador				9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park	
9c. COUNTY OF DEATH Mongtomery County				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Hyattsville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 6322 20th Avenue	
10f. ZIP CODE 20782				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Salvadorian			
14. RACE — American Indian, Black, White, etc. Specify: Hispanic				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer				16b. KIND OF BUSINESS/INDUSTRY Construction Industry			
17. FATHER'S NAME (First, Middle, Last) Gregorio Garcia				18. MOTHER'S NAME (First, Middle, Maiden Surname) Petronila Rodriguez			
19a. INFORMANT'S NAME (Type/Print) Juana Amaya Garcia				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6322 20th Avenue, Hyattsville, Maryland 20782			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 11/15/95 Cementerio General De Sensuntepeque El Salvador			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lisa S. Johnson			
22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. INTRACEREBRAL HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): b. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): c. ANTICOAGULATION DUE TO (OR AS A CONSEQUENCE OF): d. PREVIOUS MYOCARDIAL INFARCTION Approximate Interval Between Onset and Death 24 HR YEARS 1 MONTH 7 MONTHS			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Ernesto Africano, M.D. 29c. LICENSE NUMBER D-19400 29d. DATE SIGNED (Month, Day, Year) 11-9-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ERNESTO AFRICANO, M.D. 831 UNIVERSITY BLVD. SILVER SPRING, MD.				31. DATE FILED (Month, Day, Year) NOV 13 1995 32. REGISTRAR'S SIGNATURE John Davidson-Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36123

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALICE A. GIRARD				2. DATE OF DEATH MONTH DAY YEAR November 10, 1995		3. TIME OF DEATH HOURS MINUTES 4:48 A M	
4. SOCIAL SECURITY NUMBER 579-54-0635		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 27, 1905	
8. FACILITY NAME (If not institution, give street and number) 1111 Clovis Avenue				9. CITY, TOWN OR LOCATION OF DEATH Capitol Heights		10. COUNTY OF DEATH Prince Georges	
10a. STATE MD		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Capitol Heights		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1111 Clovis Avenue				10f. ZIP CODE 20743		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Registered Nurse		16b. KIND OF BUSINESS/INDUSTRY Montclair Hospital/NJ			
17. FATHER'S NAME (First, Middle, Last) Matthew Anderson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Susan Miller			
19a. INFORMANT'S NAME (Type/Print) Susan Revis-Piatt				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16620 Sylvan Dr., Bowie, MD 20715			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON NATIONAL CEMETERY		DATE Nov. 16		20c. LOCATION — City or Town, State ARLINGTON, VIRGINIA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J.P. Marshall</i>				22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home, Inc. 4308 Suitland Rd., Suitland, MD 20746			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Metastatic melanoma DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nonlethal		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>P. Basch MD</i>				29c. LICENSE NUMBER D25920		29d. DATE SIGNED (Month, Day, Year) 11/13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter Basch, M.D. - 666 Pennsylvania Ave. SE Washington, D.C. 20002							
31. DATE FILED (Month, Day, Year) NOV 16 1995				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

153

NOV 16 1932
J. H. H. H. H.

95 36124

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANGELA MADIGAN HANNAN				2. DATE OF DEATH MONTH DAY YEAR NOV. 8, 1995		3. TIME OF DEATH 4:00 A M	
4. SOCIAL SECURITY NUMBER 579-34-4939		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 12, 1927	
9a. FACILITY NAME (If not institution, give street and number) 5504 BEECH AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BETHESDA		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5504 BEECH AVENUE				10f. ZIP CODE 20814		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5 +		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) JOSEPH P. MADIGAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) EILEEN KEADY			
19a. INFORMANT'S NAME (Type/Print) JOHN A. POWER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11110 TATTERSALL TERRACE OAKTON, VA 22124			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY 11/11		20c. LOCATION — City or Town, State SILVER SPRING, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> MD0956				22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLERS SONS 5130 WI AVE NW WASHINGTON DC 20016			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinomatosis Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { a. Carcinoma of Breast b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 6 mo 8 year	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, lecture, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeremy V. Cooke MD</i>				29c. LICENSE NUMBER D04602		29d. DATE SIGNED (Month, Day, Year) 11/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeremy V. Cooke MD, 10400 Conn. Ave, Kensington MD							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>John A. Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

REG NO

DHMM-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36126

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Jeymour Harrison</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Nov 12 1995</i>		3. TIME OF DEATH <i>10:20 AM</i>	
4. SOCIAL SECURITY NUMBER <i>099-14-4833</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>71</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>April, 7, 1924</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>		9c. COUNTY OF DEATH <i>Mont.</i>	
10a. STATE <i>Md.</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>11705 Kemp Mill Rd.</i>				10f. ZIP CODE <i>20902</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WWII</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Electronics Engineer</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Private</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Aaron Clement Harrison</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Bertha Gertsner</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Arthur Harrison</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5002 Barkwood Place Rockville, Md. 20853</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mt. Lebanon Cemetery 11/13/95</i>		20c. LOCATION — City or Town, State <i>Adelphi, Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Perforated Abdominal Ulcers.</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>Valvular Aortic Disease.</i> b. DUE TO (OR AS A CONSEQUENCE OF): <i>Coronary Heart Disease.</i> c. DUE TO (OR AS A CONSEQUENCE OF): <i>Renal Insuff.</i> d.							Approximate Interval Between Onset and Death <i>3 Weeks</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify):					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>E 22130</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/12/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>10313 Germantown Ave. Suite 207 Silver Spring.</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 14 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36127

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Roberta Tapley Hanley				2. DATE OF DEATH MONTH DAY YEAR November 11, 1995				3. TIME OF DEATH 5:00 A.M.	
4. SOCIAL SECURITY NUMBER 214-42-4001		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 10, 1909		8. BIRTHPLACE (State or Foreign Country) Maine	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 14413 Briarwood Terrace				10f. ZIP CODE 20853		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Robert Morris Tapley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes Gould					
19a. INFORMANT'S NAME (Type/Print) Kathleen A. Hanley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14413 Briarwood Terrace, Rockville, MD 20853					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery Nov. 14, 1995		20c. LOCATION — City or Town, State Silver Spring, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Randy Fawcett</i> M00198				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Azotemia DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death 1 week	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Stroke								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christopher Dunford</i>				29c. LICENSE NUMBER D31839		29d. DATE SIGNED (Month, Day, Year) November 13, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christopher Dunford, M.D. 615 West Montgomery Avenue, Rockville, Maryland 20850									
31. DATE FILED (Month, Day, Year) NOV 14 1995				32. REGISTRAR'S SIGNATURE <i>John Anderson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36128

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George Shaw Holman, Jr.				2. DATE OF DEATH MONTH DAY YEAR November 10, 1995		3. TIME OF DEATH 2:20 A M	
4. SOCIAL SECURITY NUMBER 578-14-4128		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 9, 1911	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE N/A		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Washington, D.C.		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5428 41st Street, N.W.				10f. ZIP CODE 20015		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942-1946		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Office Manager		16b. KIND OF BUSINESS/INDUSTRY Womack, Inc.			
17. FATHER'S NAME (First, Middle, Last) George Shaw Holman, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Marsh			
19a. INFORMANT'S NAME (Type/Print) Elsie M. Holman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5428 41st St. N.W. Washington, DC 20015			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 11/13/95		20c. LOCATION — City or Town, State Alexandria, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death 3 Wks.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Adult Respiratory Distress Syndrome DUE TO (OR AS A CONSEQUENCE OF):					3 Wks.
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cytomegalovirus Pneumonia, Lymphoma							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 024571		29d. DATE SIGNED (Month, Day, Year) 11/14/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 11701 Georgia Ave Wheaton MD Jay H. Weiner MD							
31. DATE FILED (Month, Day, Year) NOV 15 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36129

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert L. Harding				2. DATE OF DEATH MONTH DAY YEAR November 13, 1995		3. TIME OF DEATH 3:55 A.M.	
4. SOCIAL SECURITY NUMBER 242-60-8177		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 14, 1939	
9a. FACILITY NAME (If not institution, give street and number) Laurel Regional Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Laurel		9c. COUNTY OF DEATH Prince Georges	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Laurel		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 11332 Laurel Walk Drive				10f. ZIP CODE 20708		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Pan Operator		16b. KIND OF BUSINESS/INDUSTRY Milk Producers Assoc.	
17. FATHER'S NAME (First, Middle, Last) William H. Harding				18. MOTHER'S NAME (First, Middle, Maiden Surname) Deacy Graddy			
19a. INFORMANT'S NAME (Type/Print) Mable R. Harding (wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11332 Laurel Walk Dr., Laurel, MD 20708			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Nat'l Mem.Pk 11/17		20c. LOCATION — City or Town, State Laurel, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSER <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Gastric Carcinoma - Terminal							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. Liver Failure because of metastasis							
c. Severe Anemia							
d. Left lower lobe Pneumonia							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peptic ulcer disease Partial gastrectomy twenty years ago							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one)			
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John B. Theobalds MD</i>				29c. LICENSE NUMBER D23350		29d. DATE SIGNED (Month, Day, Year) 11-13-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN B THEOBALDS MD 9811 MALLARD DR. LAUREL MD							
31. DATE FILED (Month, Day, Year) NOV 15 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.



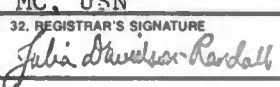
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36130

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVELYN ANDREWS HAZELETT				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 12 1995		3. TIME OF DEATH 2:45 A M	
4. SOCIAL SECURITY NUMBER 343-01-2536		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 13, 1918 Illinois	
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4912 Cloister Drive				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Private Industry			
17. FATHER'S NAME (First, Middle, Last) Carl M. Andrews				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Kruzinski			
19a. INFORMANT'S NAME (Type/Print) Evelyn Spicer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10918 Wickshire Way North Bethesda, Maryland 20852			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) November 15, 1995 Arlington National Cemetery		20c. LOCATION — City or Town, State Arlington, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0335				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CIRCULATORY COLLAPSE DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST SEVERE MULTI VESSEL CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  BROOKS D. CASH, LT, MC, USN				29c. LICENSE NUMBER 0101051813 (VA)		29d. DATE SIGNED (Month, Day, Year) 11/13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600							
31. DATE FILED (Month, Day, Year) NOV 16 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36131

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dr. PATRICK R. M. HUGHES, Sr.				2. DATE OF DEATH MONTH DAY YEAR November 9, 1995		3. TIME OF DEATH 2:15 P M	
4. SOCIAL SECURITY NUMBER 588-54-2359		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 31, 1930	
8. BIRTHPLACE (State or Foreign Country) Guyana				9a. FACILITY NAME (If not institution, give street and number) Manor Care Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Chevy Chase	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5609 Alta Vista Road	
10f. ZIP CODE 20817				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Afro-Guyanese	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) +5				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Professor		16b. KIND OF BUSINESS/INDUSTRY University	
17. FATHER'S NAME (First, Middle, Last) Abraham J. Hughes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lilian Smith			
19a. INFORMANT'S NAME (Type/Print) Patrick R.M. Hughes, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5609 Alta Vista Road, Bethesda, Maryland 20817			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 11/10		20c. LOCATION — City or Town, State Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kenie' Hunt-Holland</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → STROKE							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): PULMONARY Embolism							
b. DUE TO (OR AS A CONSEQUENCE OF): HYPERCOAGULABILITY							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles A. Smith</i>				29c. LICENSE NUMBER D43496		29d. DATE SIGNED (Month, Day, Year) 11/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOHAMMAD A KHALID MD 1299- Cambridge Drive Silver Spring 20902							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36132

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA E HOGAN				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 11 1995		3. TIME OF DEATH 6:25 P M	
4. SOCIAL SECURITY NUMBER 119-03-6954		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 2, 1919	
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6212 Redwing Court				10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY D.C. Schools			
17. FATHER'S NAME (First, Middle, Last) John Esau				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Shannon			
19a. INFORMANT'S NAME (Type/Print) Harry J. Hogan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6212 Redwing Court Bethesda, Maryland 20817			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 11/17/95 Arlington National Cemetery		20c. LOCATION — City or Town, State Arlington, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Timothy J. Campbell</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CANCER							
Due TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. Due TO (OR AS A CONSEQUENCE OF):							
c. Due TO (OR AS A CONSEQUENCE OF):							
d. Due TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>MA Blackmon</i>				29c. LICENSE NUMBER VA 0101052849		29d. DATE SIGNED (Month, Day, Year) 11 Nov 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.L. BLACKMON, MD I.T. MC, USN				31. DATE FILED (Month, Day, Year) NOV 17 1995			
32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

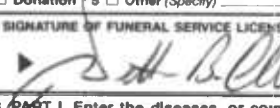
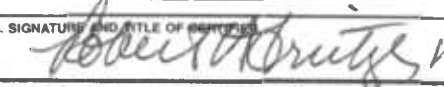
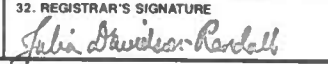
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36133

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) SARA E. HADLEY				2. DATE OF DEATH MONTH NOV. DAY 12, YEAR 1995		3. TIME OF DEATH 8:45 A M	
4. SOCIAL SECURITY NUMBER 511-11-0446		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 6, 1918	
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Olney		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Sandy Spring		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 17340 Quaker Lane				10f. ZIP CODE 20860		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Archivist		16b. KIND OF BUSINESS/INDUSTRY Non-profit Organization			
17. FATHER'S NAME (First, Middle, Last) J. Perry Hadley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Motter			
19a. INFORMANT'S NAME (Type/Print) Carol Hadley Brown (Niece)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7014 Clearview St, Philadelphia, PA 19119			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory		DATE 11-15		20c. LOCATION — City or Town, State Beltsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. DUE TO (OR AS A CONSEQUENCE OF): Pseudomembranous Colitis</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death Days Weeks</p> </div> </div>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prior CVA							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER D 37930		29d. DATE SIGNED (Month, Day, Year) November 12, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT H TWITTEN MD 1841 Prince Philip Dr #312 OLNEY, MD 20832							
31. DATE FILED (Month, Day, Year) NOV 17 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #1, 11/13/95, MRT, Montgomery County
 FOR
 1 - STATE REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RICHARD HARRINGTON John Harrington				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 09, 1995		3. TIME OF DEATH M 1500	
4. SOCIAL SECURITY NUMBER 214-30-0379		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 14, 1932	
8a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital				8b. CITY, TOWN OR LOCATION OF DEATH TAKOMA PARK, MARYLAND		8c. COUNTY OF DEATH MONTGOMERY	
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Hyattsville		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 6705 22nd Place				10f. ZIP CODE 20782		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1951-1954		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant Certified Public		16b. KIND OF BUSINESS/INDUSTRY Accounting			
17. FATHER'S NAME (First, Middle, Last) Elmer Adna Harrington				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Anna Brower			
19a. INFORMANT'S NAME (Type/Print) Katharina E. Harrington				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6705 22nd Place, Hyattsville, MD 20782			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 11/15/95 Arlington National Cemetery		20c. LOCATION — City or Town, State Arlington, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven J. Stoud				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory arrest b. Pontine stroke c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 1 wk							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Rashid Baghai Naimi				29c. LICENSE NUMBER D39372		29d. DATE SIGNED (Month, Day, Year) November 10 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rashid Baghai Naimi M.D. 324 University Blvd. Suit 324 Silver Spring MD 20901							
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE John A. Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36135

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) David Henry Hauck, Jr.				2. DATE OF DEATH MONTH Nov 14, DAY 1995 YEAR		3. TIME OF DEATH 4:15 PM M	
4. SOCIAL SECURITY NUMBER 220-36-7776		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar 31, 1941	
9a. FACILITY NAME (If not institution, give street and number) 1006 Main Street, South Rear				9b. CITY, TOWN OR LOCATION OF DEATH Hampstead		9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Hampstead		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1006 Main Street, South Rear				10f. ZIP CODE 21074		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) David Henry Hauck, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Catherine Fitch			
19a. INFORMANT'S NAME (Type/Print) Carole J. Hauck				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 324, Hampstead, MD 21074			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Carroll Cremations		DATE 11/15		20c. LOCATION — City or Town, State Hampstead, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven W. Eline</i>				22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 934 S Main St, Hampstead, MD 21074			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic lung cancer.</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <i>6 months</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Home</i>					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Vincent P Wroblewski MD</i>				29c. LICENSE NUMBER <i>043031</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/15/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>VINCENT P WROBLEWSKI, MD, 2205 YORK RD TIMONUM, MD</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 17 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36136

Amended item #'s 18 & 20b per F.D. Carroll Co. P.L.C. 11/17/95

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Francis Clayton Hewitt				2. DATE OF DEATH MONTH DAY YEAR Nov. 14, 1995		3. TIME OF DEATH 6:10A.M.	
4. SOCIAL SECURITY NUMBER 214-20-9213		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 18, 1926	
9a. FACILITY NAME (If not institution, give street and number) Westminster Nursing & Convalescent Center				9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll	
10a. STATE Maryland				10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 30 Locust Street, Apt 604			
10f. ZIP CODE 21157				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII - Army		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mail Room Clerk		16b. KIND OF BUSINESS/INDUSTRY Social Security Admin.			
17. FATHER'S NAME (First, Middle, Last) Joseph M. Hewitt Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lena Jane Boudoff Bottorff			
19a. INFORMANT'S NAME (Type/Print) Michele V. Wagner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 707, Manchester, Md. 21102			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Westminster Cemetery 11/16		20c. LOCATION — City or Town, State Westminster, Md. 21157			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nancy K. Fletcher</i>				22. NAME AND ADDRESS OF FACILITY Fletcher Funeral Home 254 E. Main Street, Westminster, Md. 21157			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary Artery Disease</i> Approximate Interval Between Onset and Death <i>6 mo</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Marshall MD</i>				29c. LICENSE NUMBER <i>032882</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/15/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>114 Business Center Drive Reisterstown, MD 21136</i>							
31. DATE FILED (Month, Day, Year) NOV 17 1995		32. REGISTRAR'S SIGNATURE <i>Julia Wheeler-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36137

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nancy Marie Hicks				2. DATE OF DEATH MONTH DAY YEAR November 15, 1995		3. TIME OF DEATH 11:09 A M	
4. SOCIAL SECURITY NUMBER 219-56-0333		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUGUST 23, 1914	
9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH La Plata		9c. COUNTY OF DEATH Charles	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY CHARLES		10c. CITY, TOWN OR LOCATION INDIAN HEAD		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER #9 PUEBLO CIRCLE				10f. ZIP CODE 20640		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH GRADE		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC		16b. KIND OF BUSINESS/INDUSTRY PRIVATE			
17. FATHER'S NAME (First, Middle, Last) ALBERT HAWKINS				18. MOTHER'S NAME (First, Middle, Maiden Surname) HARRIET HICKS HAWKINS			
19a. INFORMANT'S NAME (Type/Print) CATHERINE L. HICKS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) #9 PUEBLO CIRCLE, INDIAN HEAD, MARYLAND 20640			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, City or Town, State, Zip Code) TRINITY CHURCH CEMETERY 11/20/95 NEWPORT, MARYLAND		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>India C. Thornton Johnson</i> INDIA C. THORNTON JOHNSON MO0583				22. NAME AND ADDRESS OF FACILITY THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <i>years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Charles A. Drake</i> MD				29c. LICENSE NUMBER D27346		29d. DATE SIGNED (Month, Day, Year) 11/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Hester P. Box 1697 Waldo, F Md 20604</i>							
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36138

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles M. Henry				2. DATE OF DEATH MONTH October DAY 31 , YEAR 1995				3. TIME OF DEATH 11:50A M	
4. SOCIAL SECURITY NUMBER 188-16-594		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7. DATE OF BIRTH (Month, Day, Year) Aug 25, 1920				8. BIRTHPLACE (State or Foreign Country) MD					
9a. FACILITY NAME (If not institution, give street and number) Perry Point VA Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Perry Point, Maryland				9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3800 W. Belvedere Ave				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES OCT 1941 - Nov. 1942		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Charles Henry				18. MOTHER'S NAME (First, Middle, Maiden Surname) Viola Pitts					
19a. INFORMANT'S NAME (Type/Print) CLARA Henry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 340 Friendship Ct ELKTON, MD					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet Cem 10-9		DATE 10-9		20c. LOCATION — City or Town, State Owings Mill, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY BOARD Funeral Home 552 Lewis St Haver de Grace, MD					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrhythmia DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): c. Severe Obstructive Pulmonary Failure DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 4 Hours 4 Hours 10 Years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Unstable Angina								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 341608				29d. DATE SIGNED (Month, Day, Year) 10-31-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EUGENE CRAIG, M.D., YAMC, Perry Point, MD 21902									
31. DATE FILED (Month, Day, Year) NOV 9 1995				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 36139

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Daylon				2. DATE OF DEATH MONTH DAY YEAR November 5, 1995				3. TIME OF DEATH 9:07 A M	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 25		7. DATE OF BIRTH (Month, Day, Year) OCT. 10, 1969		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH Baltimore County	
10a. STATE MD		10b. COUNTY HARFORD		10c. CITY, TOWN OR LOCATION ABERDEEN				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 749 BATTLE AVENUE				10f. ZIP CODE 21001		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) MARRIN C. HOLLAND				18. MOTHER'S NAME (First, Middle, Maiden Surname) HAZEL E. HOLLAND					
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 749 BATTLE AVE, ABERDEEN, MD 21001					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) M. CALVARY CEMETERY 11/7/95		20c. LOCATION — City or Town, State ABERDEEN, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY BEARD FUNERAL HOME 21078 652 LEWIS ST. NAURE DE GRAVE, MD									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): b. Chronic Lung Disease DUE TO (OR AS A CONSEQUENCE OF): c. Prematurity DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 3 days 25 days 25 days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Kottapalli M.D.							
		29c. LICENSE NUMBER D 22511				29d. DATE SIGNED (Month, Day, Year) 11/5/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sita Kottapalli M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237									
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VINCENT HOLMES				2. DATE OF DEATH MONTH DAY YEAR November 11, 1995		3. TIME OF DEATH 9:00 AM	
4. SOCIAL SECURITY NUMBER 218-30-3316		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 14, 1933	
8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) 1531 Dunwoody Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Oxon Hill		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Oxon Hill		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1531 Dunwoody Avenue				10f. ZIP CODE 20745		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 10th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Driver		16b. KIND OF BUSINESS/INDUSTRY Government			
17. FATHER'S NAME (First, Middle, Last) Thornton Holmes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Fleet			
19a. INFORMANT'S NAME (Type/Print) Debra Holmes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1531 Dunwoody Avenue, Oxon Hill, MD 20745			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony 11-18		20c. LOCATION — City or Town, State Landover, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Inawana L. Braxton</i>				22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Rd, Landover, MD 20745			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Squamous Carcinoma, metastatic DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto L. Rodriguez MD</i>				29c. LICENSE NUMBER 221230		29d. DATE SIGNED (Month, Day, Year) November 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) August P. Rodriguez MD, 5009 Rayburn Ct. Sp. Md 20745							
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00177

1-10-52

1-10-52

NOV 13 1952
FBI - NEW YORK

95 36141

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William Lee HOOKER</i>				2. DATE OF DEATH MONTH DAY YEAR <i>November 8, 1995</i>		3. TIME OF DEATH <i>0154 AM</i>	
4. SOCIAL SECURITY NUMBER <i>241-18-1325</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>73</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>January 9, 1922</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Liberty, N.C.</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Doctors Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Greenbelt, Maryland.</i>	
9c. COUNTY OF DEATH <i>Prince Georges</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince Georges</i>	
10c. CITY, TOWN OR LOCATION <i>Hyattsville, Maryland.</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>1808 Langford</i>	
10f. ZIP CODE <i>20782</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>African American</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th Grade</i> College (1-4 or 5+) <i>Truck Driver</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Truck Driver</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Private</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Roy Hooker</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Gertrude Gales Hooker</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Vinnie Delores Craig Hooker</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1808 Langford Hyattsville, Maryland 20782.</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Amos Grove Cemetery November 15, 1995.</i>			
20c. LOCATION — City or Town, State <i>Liberty, N.C.</i>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward W. Jones</i>			
22. NAME AND ADDRESS OF FACILITY <i>W.H. Bacon Funeral Home 3447-14th Street, N.W. Washington, D.C. 20010</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Diabetes Mellitus with Acidosis</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Respiratory Failure</i> b. <i>Cardiovascular System Failure</i> c. <i>renal insufficiency</i> d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)			
28b. TIME OF INJURY <i>M</i>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D14156</i>			
29d. DATE SIGNED (Month, Day, Year) <i>11-8-95</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>CIRO A. Montez, MD 1300 Wercantkplace - bawolover, MD</i>			
31. DATE FILED (Month, Day, Year) <i>NOV 13 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36142

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Lionell Wayne HOLMES</u>				2. DATE OF DEATH MONTH DAY YEAR <u>November 5 1995</u>		3. TIME OF DEATH <u>6:55 A^M</u>	
4. SOCIAL SECURITY NUMBER <u>579-68-6386</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>43</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>January 21, 1952</u>	
8. FACILITY NAME (If not Institution, give street and number) <u>Doctors Community Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Lanham</u>		9c. COUNTY OF DEATH <u>Prince Georges</u>	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION <u>Landover</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Prince George's</u>		10e. STREET AND NUMBER <u>3302 Barcroft Drive</u>		10f. ZIP CODE <u>20785</u>	
10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Pharmacy Assistant</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Government</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Alonzo G. Holmes</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Lillie Mae Milton</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Alonzo Holmes</u> / BROTHER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2721 31st St., SE #B567, Washington, DC 20020</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Harmony Memorial Park</u> <u>11/10</u>		20c. LOCATION — City or Town, State <u>Landover, Maryland</u>		22. NAME AND ADDRESS OF FACILITY <u>J. B. Jenkins Funeral Home</u> <u>7474 Landover Road, Landover, MD 20785</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Quawana D. Braxton</u>				22. NAME AND ADDRESS OF FACILITY <u>J. B. Jenkins Funeral Home</u> <u>7474 Landover Road, Landover, MD 20785</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ethanol, fluoxetine</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Augusto P. Rodriguez MD</u>				29c. LICENSE NUMBER <u>D21230</u>		29d. DATE SIGNED (Month, Day, Year) <u>November 15/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Mail to P. Rodriguez MD, 5009 Rayburn Ct. Ap. 505 - Md 20748</u>							
31. DATE FILED (Month, Day, Year) <u>NOV 13 1995</u>				32. REGISTRAR'S SIGNATURE <u>John Andrew Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

(3)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 36143

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM E. HENRY Jr.				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 5, 1995		3. TIME OF DEATH 3:00P	
4. SOCIAL SECURITY NUMBER 189 22 2125		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 21 1930	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bowie		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 13111 Idlewild Drive				10f. ZIP CODE 20715		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Special Assistant Labor Relations		15b. KIND OF BUSINESS/INDUSTRY U.S. Postal Service			
17. FATHER'S NAME (First, Middle, Last) William E. Henry, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Conn			
19a. INFORMANT'S NAME (Type/Print) Dorothy Henry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13111 Idlewild Drive Bowie Md. 20715			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cemetery 11/10/95		20c. LOCATION — City or Town, State Clinton Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres.		22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Aspiration Pneumonia, Left Lower Lobe DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Bronchogenic Carcinoma with Generalized Metastases DUE TO (OR AS A CONSEQUENCE OF): Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James S. Steubing MD				29c. LICENSE NUMBER D12015		29d. DATE SIGNED (Month, Day, Year) 11-6-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Louis Steinberg 6492 Landover Rd Landover, Md 20785							
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE John Andrew Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 36144

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUTH HEURICH				2. DATE OF DEATH MONTH NOVEMBER DAY 1 , YEAR 1995		3. TIME OF DEATH 7:20 AM	
4. SOCIAL SECURITY NUMBER 579 10 4830		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 4 1917	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Hyattsville		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3546 Manor Wood Drive				10f. ZIP CODE 20782		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Robert V. Guttridge				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lula Mae Washington			
19a. INFORMANT'S NAME (Type/Print) June H. DeVito				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3304 Royale Glen Ave. Davidsonville Md. 21035			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 11/4/95		20c. LOCATION — City or Town, State Silver Spring Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans, Pres				22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Cardiovascular Collapse DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death 1 day
If sequentially list conditions, after leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Neurotic Bowel and Septic DUE TO (OR AS A CONSEQUENCE OF):					2 weeks
		c. Generalized Atherosclerotic Vascular disease DUE TO (OR AS A CONSEQUENCE OF):					years
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D 46093		29d. DATE SIGNED (Month, Day, Year) 11/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kedman Mostaghim 3305 Hanover Pkwy Greenbelt, MD 20770							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36145

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Horwat		2. DATE OF DEATH MONTH DAY YEAR Nov. 5, 1995		3. TIME OF DEATH 7:30 PM	
4. SOCIAL SECURITY NUMBER 175 14 3748		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.	
7. DATE OF BIRTH (Month, Day, Year) May 3, 1918		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) 12706 Beaverdale Lane			9b. CITY, TOWN OR LOCATION OF DEATH Bowie		9c. COUNTY OF DEATH Prince George's
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bowie	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 12706 Beaverdale Lane			10f. ZIP CODE 20715		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No	
14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Andrew Kino			18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Pankuch		
19a. INFORMANT'S NAME (Type/Print) Betty Fike			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12706 Beaverdale Lane Bowie Maryland 20715		
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 11/6/95 Alexandria Virginia		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Evans, Pres</i>			22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Cardiorespiratory Arrest		Approximate interval Between Onset and Death minutes	
		b. Metastatic ovarian cancer		months	
		c. Anemia		months	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO N/A	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M	
		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Anne Rose Eapen M.D.</i>		29c. LICENSE NUMBER 0101045101		29d. DATE SIGNED (Month, Day, Year) 11/6/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANNE ROSE N. EAPEN, M.D. 1760 RESTON PKWY #310 RESTON, VA 22090					
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36146

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY NALLEY HENNEN				2. DATE OF DEATH MONTH NOVEMBER DAY 8 YEAR 1995		3. TIME OF DEATH 4:50A M						
4. SOCIAL SECURITY NUMBER 215-60-9690		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) January 8, 1918		8. BIRTHPLACE (State or Foreign Country) Washington, DC				
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH Baltimore City				
10a. STATE Maryland			10b. COUNTY Prince George's			10c. CITY, TOWN OR LOCATION Capital Heights			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1907 Elmwood Park Drive				10f. ZIP CODE 20743			10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) Jack Nalley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Notley								
19a. INFORMANT'S NAME (Type/Print) Estal J. Hennen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1907 Elmwood Park Drive, Capital Heights, MD 20743								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olivet Cemetery 11/10/95			20c. LOCATION — City or Town, State Washington, D.C.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Henry J. Ford</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multi-System organ Failure One Week DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis One Week DUE TO (OR AS A CONSEQUENCE OF): c. Colonic Ischemia Three Weeks DUE TO (OR AS A CONSEQUENCE OF): d. Cervical Cancer One Year Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Thrombocytopenia, uremia, jaundice									24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. SIGNATURE AND TITLE OF CERTIFIER Robert Ferri's Intern in Surgery			29c. LICENSE NUMBER L 9527		29d. DATE SIGNED (Month, Day, Year) November 8, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Ferri's 124 East Lake Avenue, Baltimore, MD 21210												
31. DATE FILED (Month, Day, Year) NOV 13 1995			32. REGISTRAR'S SIGNATURE <i>Julia Duckworth</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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95 36147

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Roberta Chavis Johnson				2. DATE OF DEATH MONTH DAY YEAR Nov. 7, 1995		3. TIME OF DEATH 9:22 p M	
4. SOCIAL SECURITY NUMBER 578-60-4825		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 99 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 27, 1896	
8. BIRTHPLACE (State or Foreign Country) N. Carolina				9a. FACILITY NAME (If not institution, give street and number) Regency Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Forestville	
9c. COUNTY OF DEATH PRINCE GEORGES				10a. STATE Maryland		10b. COUNTY Prince Georges	
10c. CITY, TOWN OR LOCATION Upper Marlboro				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 12803 Staton Court	
10f. ZIP CODE 20772				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse		16b. KIND OF BUSINESS/INDUSTRY Medical	
17. FATHER'S NAME (First, Middle, Last) Jordan D. Chavis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cornelia E. Dorset			
19a. INFORMANT'S NAME (Type/Print) Guy H. Johnson (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7820 Brink Road, Gaithersburg, MD 20882			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Mem. Cem. 11/11		20c. LOCATION — City or Town, State Suitland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → DECUBE ULCER DUE TO (OR AS A CONSEQUENCE OF): SENILITY Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Gastritis; Dysphagia.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gastritis; Dysphagia.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1. <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER S. J. KAO, MD				29c. LICENSE NUMBER D-36525		29d. DATE SIGNED (Month, Day, Year) 11-08-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type/Print) 4000 - Mitchellville Road, #120, Bowie, MD 20716							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36148

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BARRY GRANT JOHNSON				2. DATE OF DEATH MONTH DAY YEAR NOV 9 1995		3. TIME OF DEATH 6:04 P M	
4. SOCIAL SECURITY NUMBER 579-92-4684		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 32 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-4-63	
9a. FACILITY NAME (If not institution, give street and number) southern Maryland Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Clinton		9c. COUNTY OF DEATH Prince Georges	
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Upper Marlboro		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 14328 Colonel Claggett Court				10f. ZIP CODE 20772		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Service Advisor		16b. KIND OF BUSINESS/INDUSTRY Automobile Dealer			
17. FATHER'S NAME (First, Middle, Last) Clemson Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cubie Lee			
19a. INFORMANT'S NAME (Type/Print) Clemson Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14328 Colonel Claggett Court, Upper Marlboro			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Mem. Park		20c. LOCATION — City or Town, State 11-16 Landover, Md		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Strickland Funeral Svc 9507 Silver Fox Turn, Clinton, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Respiratory Distress Syndrome DUE TO (OR AS A CONSEQUENCE OF): b. Bilateral Pneumonia most probably Pneumococcal DUE TO (OR AS A CONSEQUENCE OF): c. Acquired Immunodeficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Renal Failure							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 11/9/95		28b. TIME OF INJURY 6:04 PM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> , M.D.				29c. LICENSE NUMBER D43276		29d. DATE SIGNED (Month, Day, Year) 11/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) IMELDA R. MIRANDA, M.D. 9556 CRAIN HIGHWAY UPPER MARLBORO MD 20772							
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

201

10-10-1955

95-6806-033
B.K.S

95 36149

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD E. JEMISON				2. DATE OF DEATH MONTH DAY YEAR NOV. 08, 1995		3. TIME OF DEATH 12:25 P M	
4. SOCIAL SECURITY NUMBER 277-18-8316		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 12, 1911	
9a. FACILITY NAME (If not institution, give street and number) AAFB ANDREWS HOSPITAL (MALCOM GROW)				9b. CITY, TOWN OR LOCATION OF DEATH CAMP SPRINGS		9c. COUNTY OF DEATH PRINCE GEORGES	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGE'S		10c. CITY, TOWN OR LOCATION LANHAM		10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
10e. STREET AND NUMBER 5007 BALTIMORE LANE				10f. ZIP CODE 20706		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX YES 2 NO IF YES, GIVE WAR OR DATES NAVY 11/7/34- 5/1/65		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHIEF PETTY OFFICER		16b. KIND OF BUSINESS/INDUSTRY RETIRED US NAVY GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last) JAMES JEMISON				18. MOTHER'S NAME (First, Middle, Maiden Surname) LOUVENIA HAL			
19a. INFORMANT'S NAME (Type/Print) FRANCES JEMISON/ WIFE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5007 BALTIMORE LANE LANHAM, MD 20706			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERAN CEM. 11-15-95		DATE 11-15-95		20c. LOCATION — City or Town, State CHELTHENHAM, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mawana Braxton</i>				22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD. LANDOVER, MD 20785			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chest Injuries Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 11/8/95		28b. TIME OF INJURY 1122 M		28c. INJURY AT WORK? 1 YES 2 X NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET		28e. DESCRIBE HOW INJURY OCCURRED Driver intoxicated					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) F STREET / Colorado ST.							
29a. CERTIFIER (Check one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Locke MD</i>				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) NOV. 9, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Locke MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36150

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) ISABELLE B. JONES				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 8, 1995		3. TIME OF DEATH 4:55 PM	
4. SOCIAL SECURITY NUMBER 247-36-0649		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/11/12	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hosp. Center				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
10a. STATE Md.		10b. COUNTY P.G.		10c. CITY, TOWN OR LOCATION Landover		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7216 East Kilmer St.				10f. ZIP CODE 20785		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4 or 5+) 		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Nightin Brown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth J. Emmons			
19a. INFORMANT'S NAME (Type/Print) Willie R. Jones				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Clinton Cem. 11/16/95		20c. LOCATION — City or Town, State Lancaster, S.C.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary H. Pratt</i>				22. NAME AND ADDRESS OF FACILITY H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic lymphocytic leukemia DUE TO (OR AS A CONSEQUENCE OF): a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Coronary heart failure DUE TO (OR AS A CONSEQUENCE OF): c. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): d. Stroke Approximate Interval Between Onset and Death yrs. days months days							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER DR. TAVAKOLI, M.D.		29c. LICENSE NUMBER D41978		29d. DATE SIGNED (Month, Day, Year) 11-9-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type, Print) P.G. Cheverly MD. 20785							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>Juba Shwalier Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36151

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Helene G. Jones</i>			2. DATE OF DEATH MONTH DAY YEAR <i>November 10 1995</i>		3. TIME OF DEATH <i>4:25 p.m.</i>	
4. SOCIAL SECURITY NUMBER <i>214-26-5115</i>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>87</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>OCT. 14, 1908</i>	8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i>		
9a. FACILITY NAME (If not institution, give street and number) <i>SHADY GROVE ADVENTIST HOSP.</i>			9b. CITY, TOWN OR LOCATION OF DEATH <i>ROCKVILLE</i>		9c. COUNTY OF DEATH <i>MONTGOMERY CO.</i>	
RESIDENCE OF DECEDENT						
10a. STATE <i>MD.</i>	10b. COUNTY <i>BALTIMORE CO.</i>	10c. CITY, TOWN OR LOCATION <i>CATONSVILLE</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <i>98 SMITHSWOOD AVENUE</i>		10f. ZIP CODE <i>21228</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		
14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOMEMAKER</i>		16b. KIND OF BUSINESS/INDUSTRY <i>AT HOME</i>		
17. FATHER'S NAME (First, Middle, Last) <i>WILLIAM WEHRLE</i>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ELIZABETH OLEMANN</i>			
19a. INFORMANT'S NAME (Type/Print) <i>REV.DR. RICHARD REICHARD</i>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9701- VEIRS DRIVE, ROCKVILLE, MD. 20850</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>LOUDON PARK CEMETERY 11/14</i>		20c. LOCATION — City or Town, State <i>BALTIMORE, MD.</i>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. M. Hysong</i>			22. NAME AND ADDRESS OF FACILITY <i>HYSONG CO., INC. 1300- N ST., NW, WASH., DC</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<i>Cardiovascular shock</i>		Approximate interval Between Onset and Death <i>aprox 24 hrs.</i>		
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		<i>Acute myocardial infarction</i>		<i>48 hrs</i>		
		<i>Coronary artery disease</i>		<i>years</i>		
		<i>Acute renal failure</i>		<i>1 day</i>		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles E. Kanesh M.D.</i>			29c. LICENSE NUMBER <i>021726</i>	29d. DATE SIGNED (Month, Day, Year) <i>November 11, 1995</i>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>KANESH 9710 Viers Drive, Rockville, Md 20850</i>						
31. DATE FILED (Month, Day, Year) <i>NOV 13 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36152

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Opal T. Jarrell				2. DATE OF DEATH MONTH DAY YEAR November 8, 1995				3. TIME OF DEATH 2:30 AM M			
4. SOCIAL SECURITY NUMBER 578-36-3103		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) October 25, 1911		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) Magnolia Gardens				9b. CITY, TOWN OR LOCATION OF DEATH Lanham				9c. COUNTY OF DEATH Prince George's			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Hyattsville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 3505 57th Avenue				10f. ZIP CODE 20784				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 11 College (1-4 or 5+) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Customer Service Rep				16b. KIND OF BUSINESS/INDUSTRY Department Store			
17. FATHER'S NAME (First, Middle, Last) John C. Sommers						18. MOTHER'S NAME (First, Middle, Maiden Surname) Susie Tritipoe					
19a. INFORMANT'S NAME (Type/Print) Sandra Lee Thornhill						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6503 100th Avenue, Lanham, Md. 20706					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Cemetery 11/11/95				20c. LOCATION — City or Town, State Rockville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles F. Bell				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, 4739 Baltimore Avenue, Hyattsville, Md. 20781							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate interval Between Onset and Death	
a. Metastatic Lung Cancer										1 year	
b. Uterine Cancer (Type Undetermined)										16 mos.	
c. _____											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of the knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Thomas G. Maloney, Jr. MD						29c. LICENSE NUMBER D07479		29d. DATE SIGNED (Month, Day, Year) Nov 8, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas G. Maloney, Jr. MD, 4814 71st Avenue, Hyattsville, Md. 20784											
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE John A. Wilson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION


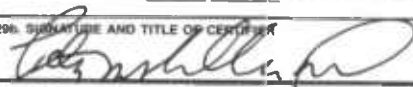
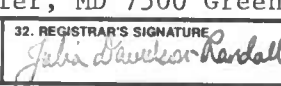
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36153

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Andree F. Jenks				2. DATE OF DEATH MONTH DAY YEAR November 7, 1995		3. TIME OF DEATH 6:00P.M.	
4. SOCIAL SECURITY NUMBER 385-16-4762		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 7, 1900	
8. BIRTHPLACE (State or Foreign Country) France				9a. FACILITY NAME (If not institution, give street and number) Collington Episcopal Life Care Community		9b. CITY, TOWN OR LOCATION OF DEATH Mitchellville	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Mitchellville				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 10450 Lottsford Road	
10f. ZIP CODE 20721				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Education	
17. FATHER'S NAME (First, Middle, Last) Maurice Fritsch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Michaud			
19a. INFORMANT'S NAME (Type/Print) Barton P. Jenks, III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 Sunset Drive, Charlestown, Rhode Island 02813			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 11/09/95		20c. LOCATION — City or Town, State Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → pneumonia, aspiration							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. Senile dementia							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D22780		29d. DATE SIGNED (Month, Day, Year) November 8, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Peter M. Schissler, MD 7500 Greenway Center Drive, #430, Greenbelt, MD 20770							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36154

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Glennie H Jenkins</i>				2. DATE OF DEATH MONTH <i>November</i> DAY <i>14</i> YEAR <i>1995</i>				3. TIME OF DEATH <i>6:30 A</i> M	
4. SOCIAL SECURITY NUMBER <i>579-46-4850</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>57</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan. 7, 1938</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Oxon Hill, MD</i>				9a. FACILITY NAME (If not institution, give street and number) <i>6237 Oxon Hill Road</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Oxon Hill</i>	
9c. COUNTY OF DEATH <i>Prince George's</i>				10a. STATE <i>MD</i>				10b. COUNTY <i>Prince George's</i>	
10c. CITY, TOWN OR LOCATION <i>Oxon Hill</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>6237 Oxon Hill Road</i>	
10f. ZIP CODE <i>20745</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>0th</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Maintenance Worker</i>				16b. KIND OF BUSINESS/INDUSTRY <i>PG County School Board</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Glennie Howard Jenkins</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Margaret F. Henson</i>				19a. INFORMANT'S NAME (Type/Print) <i>Ruth Ann West</i>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4311 23rd Parkway #912 Temple Hills, MD 20748</i>				20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Wash. National Cem. 11/17/95 Suitland, MD.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Tyrone J. Young</i>				22. NAME AND ADDRESS OF FACILITY <i>5635 Eads Street, NE Wash., DC 20019 Tyrone J. Young Funeral Services</i>				23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertensive atherosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER <i>21230</i>	
29d. DATE SIGNED (Month, Day, Year) <i>November 11, 1995</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5709 Rayburn Ct. Cp. 800, Md 20745</i>				31. DATE FILED (Month, Day, Year) <i>NOV 15 1995</i>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1952

95 36155

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Michael Krucelyak				2. DATE OF DEATH MONTH November DAY 16 , YEAR 1995		3. TIME OF DEATH 9:55 P. M	
4. SOCIAL SECURITY NUMBER 578-07-3881		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 5, 1905	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. CITY, TOWN OR LOCATION OF DEATH College Park		9c. COUNTY OF DEATH Prince George's	
9b. FACILITY NAME (If not institution, give street and number) 5715 Vassar Drive				RESIDENCE OF DECEDENT			
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION College Park		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5715 Vassar Drive				10f. ZIP CODE 20740		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 8+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Iron Worker		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) Stephen Krucelyak				18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Brudnak			
19a. INFORMANT'S NAME (Type/Print) Irene Ferber				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5906 Bryn Mawr Road College Park, Maryland 20740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cemetery November 20, 1995		20c. LOCATION — City or Town, State Clinton, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald V. Borgwardt				22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Prostate Cancer							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. Renal Cancer							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Michael Berand				29c. LICENSE NUMBER D26287		29d. DATE SIGNED (Month, Day, Year) 11/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Berand, M.D. 7305 Baltimore Avenue, #107 College Park, Md. 20740							
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DARWIN JAMES KOHLIEBER				2. DATE OF DEATH MONTH DAY YEAR NOV 14 1995		3. TIME OF DEATH 2004 P M	
4. SOCIAL SECURITY NUMBER 216-74-0803		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 34 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 18, 1961	
8. BIRTHPLACE (State or Foreign Country) Spain		9a. FACILITY NAME (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH LA PLATA	
9c. COUNTY OF DEATH CHARLES				10a. STATE Maryland			
10b. COUNTY Charles				10c. CITY, TOWN OR LOCATION Hughesville			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 14170 Robey Drive			
10f. ZIP CODE 20637				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) George Edward Kohlieber				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Elizabeth Richards			
19a. INFORMANT'S NAME (Type/Print) George S. Kohlieber				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16961 Teagues Pt. Rd., Hughesville, MD 20637			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Memorial Gardens		DATE 11-18-95		20c. LOCATION — City or Town, State Waldorf, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Benjamin Matthews M00658				22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home, Inc. P. O. box 156, Waldorf, MD 20604-0156			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Shotgun wound to Abdomen							
DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 11-14-95		28b. TIME OF INJURY 1900 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED Subject shot		28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) Residence		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 221 Robey Dr Hughesville			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER David R Fowler				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) NOV 15, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 17 1995		32. REGISTRAR'S SIGNATURE Julia Davidson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


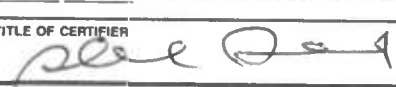
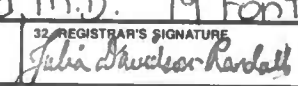
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36157

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Wilson Walker Knight Sr.				2. DATE OF DEATH MONTH November DAY 11, YEAR 1995		3. TIME OF DEATH 5:36 P.M. M	
4. SOCIAL SECURITY NUMBER 217-16-7501		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 23, 1923	
9a. FACILITY NAME (If not institution, give street and number) 512 E. Jarrettsville Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Forest Hill		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Forest Hill		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 512 E. Jarrettsville Rd.				10f. ZIP CODE 21050		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor Welding Shop		16b. KIND OF BUSINESS/INDUSTRY U.S. Govt.			
17. FATHER'S NAME (First, Middle, Last) Ralph Oliver Knight				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Jane Walker			
19a. INFORMANT'S NAME (Type/Print) Pauline N. Knight				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 E. Jarrettsville Rd. Forest Hill, Md. 21050			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris Co. 11-14-95 West Chester, Pa.		20c. LOCATION — City or Town, State Abingdon, Md. 21009		20d. DATE 11-14-95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY McComas Funeral Home 1317 Cokesbury Rd. Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		29. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D22620		29d. DATE SIGNED (Month, Day, Year) 11/13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Shahid Saeed, M.D. 19 Fontana La. Suite 104 Balto. md 21237							
31. DATE FILED (Month, Day, Year) NOV 15 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



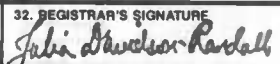
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36158

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PERCY LAWRENCE				2. DATE OF DEATH MONTH NOV. DAY 9, YEAR 1995		3. TIME OF DEATH 10:15 A M	
4. SOCIAL SECURITY NUMBER 086-07-9001		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 96 YRS.	7. DATE OF BIRTH (Month, Day, Year) DEC. 6, 1899	8. BIRTHPLACE (State or Foreign Country) GREAT BRITAIN		
9a. FACILITY NAME (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON				9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION ROCKVILLE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6105 MONTROSE ROAD				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9TH College (1-4 or 5+) AUTOMOTIVE MECHANIC		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FORD MOTOR COMPANY		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) PINCHAS LAWRENCE				18. MOTHER'S NAME (First, Middle, Maiden Surname) LEAH BLASHKEY			
19a. INFORMANT'S NAME (Type/Print) PHYLLIS MEISNER (DAUGHTER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13028 TAMARACK STREET-SILVER SPRING, MD 20904			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SHARON GARDENS 11-12 VALHALLA, NEW YORK		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cachexia DUE TO (OR AS A CONSEQUENCE OF): b. Depression DUE TO (OR AS A CONSEQUENCE OF): c. Dementia Alzheimer type DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 23958		29d. DATE SIGNED (Month, Day, Year) 11/9/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Burt I. Feldman M.D., 6121 Montrose Rd., Rockville MD 20852							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CH. 10

10

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN WESLEY LANGLEY				2. DATE OF DEATH MONTH DAY YEAR NOV. 13, 1995		3. TIME OF DEATH 12:35 P M	
4. SOCIAL SECURITY NUMBER 219 96 6944		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 30 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 13 1965	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) 7836 OLD JESSUP RD.			
10. CITY, TOWN OR LOCATION OF DEATH Jessup				11. COUNTY OF DEATH HOWARD			
12. RESIDENCE OF DECEDENT				13. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
14. STATE Maryland		15. COUNTY Prince George's		16. CITY, TOWN OR LOCATION Bowie		17. STREET AND NUMBER 12417 Stirrup Lane	
18. ZIP CODE 20715		19. CITIZEN OF WHAT COUNTRY? United States		20. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		21. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		23. RACE — American Indian, Black, White, etc. Specify: White		24. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contractor	
26. KIND OF BUSINESS/INDUSTRY Self Employed		27. FATHER'S NAME (First, Middle, Last) Joseph E. Langley		28. MOTHER'S NAME (First, Middle, Maiden Surname) Alma Hawk		29. INFORMANT'S NAME (Type/Print) Lauri Langley	
30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12417 Stirrup Lane Bowie Maryland 20715		31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Cemetery 11/17/95		32. LOCATION — City or Town, State Annapolis Maryland		33. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
34. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans, Pres.		35. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715		36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) → <i>Pneumonia Wound to Back</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>		37. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
38. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		39. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		40. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) PAWN SHOP		41. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
42. DATE OF INJURY (Month, Day, Year) 11/13/95		43. TIME OF INJURY 1230 M		44. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		45. DESCRIBE HOW INJURY OCCURRED Subject shot	
46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) pawn shop		47. LOCATION (Street and Number or Rural Route Number, City or Town, State) 7836 Old Jessup Road Jessup, Maryland		48. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		49. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King, M.D.	
50. LICENSE NUMBER OCME		51. DATE SIGNED (Month, Day, Year) NOV. 14, 1995		52. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING, M.D. 111 Penn Street, Baltimore, Maryland 21201		53. DATE FILED (Month, Day, Year) NOV 17 1995	
54. REGISTRAR'S SIGNATURE John Davidson Radcliff							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text at the bottom of the page, possibly a signature or date.

95 36160

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruth (RUTH) DUNCAN LEWIS				2. DATE OF DEATH MONTH DAY YEAR October 21 1995		3. TIME OF DEATH 1:03 PM	
4. SOCIAL SECURITY NUMBER 111-28-8199		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) January 23, 1938	
8. BIRTHPLACE (State or Foreign Country) S. Carolina							
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
10a. STATE N/A		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Washington, D.C.		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4000 Kansas Ave., N.W. #203				10f. ZIP CODE 20011		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Private			
17. FATHER'S NAME (First, Middle, Last) Allen David Duncan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie Shelton			
19a. INFORMANT'S NAME (Type/Print) Machael A. Lewis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 Lamont St., N.W. Wash. D.C. 20010			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glenwood Cemetery 11/7/95		20c. LOCATION — City or Town, State Washington, D.C.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Belva J. Jenkins				22. NAME AND ADDRESS OF FACILITY Johnson & Jenkins Inc. 716 Kennedy St., N.W. Wash. D.C. 20011			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. 1) Acute respiratory and cardiac arrest b. 2) Irreversible multiorgan failure. c. d. Approximate interval between Onset and Death 12:15 PM to 1:03 PM (48 minutes duration) EXPIRED 1:03 PM 10-21-95							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Same as above							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Farzad Assar, M.D.				29c. LICENSE NUMBER D-40201		29d. DATE SIGNED (Month, Day, Year) OCTOBER, 21 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FARZAD ASSAR, M.D. 1502 S. MAIN ST., MT AIRY, MD 21771							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE John D. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36161

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BLANCHE EVA LEWIS				2. DATE OF DEATH MONTH DAY YEAR November 4, 1995		3. TIME OF DEATH 6:30 P M	
4. SOCIAL SECURITY NUMBER 218-56-2657		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 22, 1903	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Greenbelt Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Greenbelt	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Greenbelt				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 7010 Greenbelt Road	
10f. ZIP CODE 20770				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Samuel Edward Graham				18. MOTHER'S NAME (First, Middle, Maiden Surname) Blanche Eva Lightner			
19a. INFORMANT'S NAME (Type/Print) Graham Lewis, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 Howard Drive, Port Republic, Maryland 20676			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 11/09/95		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Constance Gasch				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Jeffrey Kelman				29c. LICENSE NUMBER D20391		29d. DATE SIGNED (Month, Day, Year) November 6, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Jeffrey Kelman, 6525 Beuret Road, Hyattsville, MD 20782							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36162

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Margaret Ann Lynch</i>				2. DATE OF DEATH MONTH <i>November</i> DAY <i>13</i> , YEAR <i>1995</i>				3. TIME OF DEATH <i>10:37A</i> M	
4. SOCIAL SECURITY NUMBER <i>105-12-4064</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>76</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>October 19, 1919</i>		8. BIRTHPLACE (State or Foreign Country) <i>New York</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Doctors' Community Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Lanham</i>				9c. COUNTY OF DEATH <i>Prince George's</i>	
RESIDENCE OF DECEASED									
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince George's</i>		10c. CITY, TOWN OR LOCATION <i>Greenbelt</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>7704 Hanover Parkway</i>				10f. ZIP CODE <i>20770</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>			16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>		
17. FATHER'S NAME (First, Middle, Last) <i>John J. Daly</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Anna Estel Connor</i>					
19a. INFORMANT'S NAME (Type/Print) <i>John F. Lynch</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7704 Hanover Parkway, Greenbelt, Maryland 20770</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gate of Heaven Cemetery 11/17/95</i>			20c. LOCATION — City or Town, State <i>Silver Spring, Maryland</i>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles F. Bell</i>				22. NAME AND ADDRESS OF FACILITY <i>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>1 Hour</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>H + N</i>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gerard P. Champaloux M.D.</i>				29c. LICENSE NUMBER <i>D-20905</i>			29d. DATE SIGNED (Month, Day, Year) <i>November 13, 1995</i>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. Gerard P. Champaloux, M.D. 14300 Gallant Fox Lane, #110, Bowie, Maryland 20715</i>									
31. DATE FILED (Month, Day, Year) <i>11 NOV 15 1995</i>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CONFIDENTIAL

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Earl Luckett				2. DATE OF DEATH MONTH DAY YEAR Nov. 10 1995		3. TIME OF DEATH 2:50 a m	
4. SOCIAL SECURITY NUMBER 577-03-8687 579-44-2940		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 25, 1907	
8. BIRTHPLACE (State or Foreign Country) Washington, DC				9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Prince Georges	
10c. CITY, TOWN OR LOCATION Hyattsville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 5900 Riggs Road	
10f. ZIP CODE 20783				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 12-2-42 to 9-28-45				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Printer		16b. KIND OF BUSINESS/INDUSTRY Government	
17. FATHER'S NAME (First, Middle, Last) Arthur Luckett				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie Carter			
19a. INFORMANT'S NAME (Type/Print) Earl Luckett				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 Somerset Place, N.W., Washington, D.C. 20011			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park 11/16/95		20c. LOCATION — City or Town, State Landover, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE John T. Stewart III	
22. NAME AND ADDRESS OF FACILITY STEWART FUNERAL HOME 4001 Benning Road, N.E., Washington, D.C.		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RECURRENT ASPIRATION PNEUMONIA, BILATERAL DUE TO (OR AS A CONSEQUENCE OF): b. Cerebrovascular Accidents, Recurrent DUE TO (OR AS A CONSEQUENCE OF): c. Atherosclerotic Cerebrovascular Disease DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death Several weeks Several weeks to years Many years					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① Renal Insufficiency ② Electrolyte Imbalance ③ Coronary Heart Disease ④ IMMOBILITY DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Mohammed A. Mannan MD				29c. LICENSE NUMBER 24593		29d. DATE SIGNED (Month, Day, Year) Nov. 10-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOHAMMED A. MANNAN MD., 3715 RHODE ISLAND AVE MT. RAINIER, MD. 20712							
31. DATE FILED (Month, Day, Year) NOV 15 1995				32. REGISTRAR'S SIGNATURE John T. Stewart III			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

(5)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

-8-5

95 36164

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Laura Maria Mendez Morales				2. DATE OF DEATH MONTH November DAY 9 YEAR 1995		3. TIME OF DEATH 10:25 A M	
4. SOCIAL SECURITY NUMBER 216-82-4049		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 4, 1936	
8. BIRTHPLACE (State or Foreign Country) Venezuela				9a. FACILITY NAME (If not institution, give street and number) 7216 Oak Ridge Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Chevy Chase	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Chevy Chase				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 7216 Oak Ridge Avenue	
10f. ZIP CODE 20815				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Venezuelan		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Jose Reyes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Juana Mendez			
19a. INFORMANT'S NAME (Type/Print) Andres Morales				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7216 Oak Ridge Avenue, Chevy Chase, Maryland 20815			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery Nov. 13, 1995		20c. LOCATION — City or Town, State Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael L. Higgins</i> M00846				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Lung Carcinoma Approximate Interval Between Onset and Death acute Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): Dx 3yr ago c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition, Anemia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. S. S. AIA</i>				29c. LICENSE NUMBER 10493 D		29d. DATE SIGNED (Month, Day, Year) 11/9/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. S. S. AIA 809 Viers Mill Rd Rock MD 2085 Nov 9, 95							
31. DATE FILED (Month, Day, Year) NOV 14 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36165

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MISSOURI MOYERS				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 14, 1995		3. TIME OF DEATH 12:05 A.M.	
4. SOCIAL SECURITY NUMBER 215-80-1465		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 8, 1913	
8a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		8c. COUNTY OF DEATH Anne Arundel	
9a. STATE Maryland		9b. COUNTY Anne Arundel		9c. CITY, TOWN OR LOCATION Odenton		9d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER 711 Tolbert Drive				10b. ZIP CODE 21113		10c. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 11 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Robert Lee Burkett				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Ellen Knupp			
19a. INFORMANT'S NAME (Type/Print) Mary Sue Sheppard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 Tolbert Drive, Odenton, Maryland 21113			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Forest Oak Cemetery		20c. LOCATION — City or Town, State 11/17 Gaithersburg, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael D. Cribbens				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD. 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC ADENOCARCINOMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Joshua Imperio MD				29c. LICENSE NUMBER D454-55		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061, JOSHUA IMPERIO							
31. DATE FILED (Month, Day, Year) NOV 17 1995		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36166

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Leonard Vester McCrickard				2. DATE OF DEATH MONTH DAY YEAR November 16 1995		3. TIME OF DEATH 11:35 A M	
4. SOCIAL SECURITY NUMBER 229-18-3424		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 1, 1916	
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Olney		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 15113 Donna Drive				10f. ZIP CODE 20905		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Consultant		16. KIND OF BUSINESS/INDUSTRY Building Trades			
17. FATHER'S NAME (First, Middle, Last) Henry C. McCrickard				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lera Hicks			
19a. INFORMANT'S NAME (Type/Print) Emma T. McCrickard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15113 Donna Drive, Silver Spring, MD 20905			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 11/20/95		20c. LOCATION — City or Town, State Silver Spring, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► <i>Steven D. Stroud</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>INFARCTION, BRAIN STEM (PONS)</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>CEREBRAL ARTERIOSCLEROSIS</i> c. <i>ARTERIOSCLEROTIC CARD. DISEASE</i> d. <i>10 YRS</i> Approximate Interval Between Onset and Death <i>1 WK</i>							23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CAUCER PROSTATE</i> <i>CORONARY ARTERIOSCLEROSIS</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald R. Lewis MD</i>		29c. LICENSE NUMBER D06406		29d. DATE SIGNED (Month, Day, Year) ► NOVEMBER 16, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD R. LEWIS MD 4000 Olney-Laytonsville Road OLNEY, MD 20832							
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36167

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Melvin H. MARTIN Jr				2. DATE OF DEATH MONTH DAY YEAR November 7, 1995		3. TIME OF DEATH 6:15 p.m.	
4. SOCIAL SECURITY NUMBER 216-40-5588		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 18, 1938	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rockville	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Potomac				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 12624 Tobytown Drive	
10f. ZIP CODE 20854				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) Melvin Martin, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Clarice Martin			
19a. INFORMANT'S NAME (Type/Print) Clarice Williams (Mother)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12624 Tobytown Dr., Potomac, MD 20854					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Park Cem. 11/14		20c. LOCATION — City or Town, State Rockville, MD		20d. DATE 11/14	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: Not known Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Amit Rajvarshi M.D.</i>		29c. LICENSE NUMBER D37891		29d. DATE SIGNED (Month, Day, Year) November 7, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Amit Rajvarshi M.D. 121 Congressional Ln #409 Rockville, MD-20852							
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE <i>Julia Swanson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

4

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36168

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Esther metelits</i>				2. DATE OF DEATH MONTH DAY YEAR <i>November 9th 1995</i>		3. TIME OF DEATH <i>1230 A M</i>	
4. SOCIAL SECURITY NUMBER <i>579-16-3062</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>OCT. 20, 1918</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>LORIEN NURSING HOME</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>COLUMBIA</i>		9c. COUNTY OF DEATH <i>HOWARD</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>MONTGOMERY</i>		10c. CITY, TOWN OR LOCATION <i>SILVER SPRING</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>2203 GLENALLAN AVENUE #102</i>				10f. ZIP CODE <i>20906</i>		10g. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (13-16 or 17+) <i>2</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>BUSINESS MANAGER</i>		16b. KIND OF BUSINESS/INDUSTRY <i>RUG & UPHOLSTERY</i>			
17. FATHER'S NAME (First, Middle, Last) <i>HARRY SHAPIRO</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>SARAH KLIBANOFF</i>			
19a. INFORMANT'S NAME (Type/Print) <i>STEPHANIE WHITE</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11260-A POWDER RUN - COLUMBIA, MARYLAND 21044</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>KING DAVID MEMORIAL GARDEN</i>		DATE <i>11/12</i>		20c. LOCATION — City or Town, State <i>FALLS CHURCH, VIRGINIA</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen Brosenne</i>				22. NAME AND ADDRESS OF FACILITY <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lymphoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Gastr. intestinal Bleed</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>8 yrs</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D42187</i>		29d. DATE SIGNED (Month, Day, Year) <i>9 Nov 95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>JAMES DAY - 11055 LITTLE PATUXANT PARKWAY - COLUMBIA, MD. 21044</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 13 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gladys Clara Martinez de Moreno				2. DATE OF DEATH MONTH DAY YEAR November 7, 1995		3. TIME OF DEATH 7:35 P M	
4. SOCIAL SECURITY NUMBER 212-54-5220		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 12, 1936	
8. FACILITY NAME (If not institution, give street and number) Suburban Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 825 Loxford Terrace			
10f. ZIP CODE 20901				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Paraguayan		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Anastacio Martinez				18. MOTHER'S NAME (First, Middle, Maiden Surname) Irmina Rodriguez			
19a. INFORMANT'S NAME (Type/Print) Manuel A. Moreno				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 825 Loxford Terrace Silver Spring, Maryland 20901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 11/10/95 Silver Spring, Maryland		20c. LOCATION — City or Town, State Silver Spring, Maryland		20d. DATE 11/10/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James S. Dooly</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ventricular fibrillation							
DUE TO (OR AS A CONSEQUENCE OF): Metabolic imbalance							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF): Acute exacerbation of chronic renal failure							
DUE TO (OR AS A CONSEQUENCE OF): Hypertension; Systemic lupus; diabetes							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic Valve Endocarditis due to E. coli and Strep. Faecalis Coronary artery disease							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph A. Romeo MD</i>				29c. LICENSE NUMBER D09680		29d. DATE SIGNED (Month, Day, Year) Nov 8, 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH A. ROMEO MD - 6410 ROCKLEDGE DRIVE, BETHESDA, MD 20817							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 36170

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lulu Mae Murdock				2. DATE OF DEATH MONTH November DAY 16 , YEAR 1995				3. TIME OF DEATH 2:35 A M	
4. SOCIAL SECURITY NUMBER 215-14-2703		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7. DATE OF BIRTH (Month, Day, Year) Oct. 27, 1907				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) 123 Bond Street				9b. CITY, TOWN OR LOCATION OF DEATH Westminster				9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 123 Bond Street				10f. ZIP CODE 21157		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 7 Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Worker				16b. KIND OF BUSINESS/INDUSTRY Coca-Cola Plant	
17. FATHER'S NAME (First, Middle, Last) Josiah Washington Click				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Katherine Humerick					
19a. INFORMANT'S NAME (Type/Print) Betty J. Marsh				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 Pennsylvania Ave., Westminster, MD 21157					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Leister's Church Cemetery 11/18/95				20c. LOCATION — City or Town, State Westminster, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katherine Pille-Sweitzer				22. NAME AND ADDRESS OF FACILITY Princes Funeral Home & Chapel 412 Washington Rd., Westminster, MD 21157					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): Aortic Insufficiency Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. X d. X								Approximate Interval Between Onset and Death 7/95 7/92	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Thomas K. Galvin Jr. MD				29c. LICENSE NUMBER D31660				29d. DATE SIGNED (Month, Day, Year) 11/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1 THOMAS GALVIN MD 295 STAGER AVE WESTMINSTER MD 21157									
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE Judi Davidson-Rodell					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


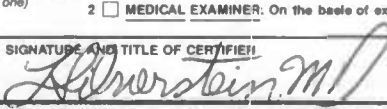
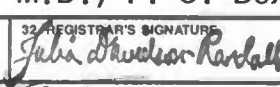
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36171

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Charles Dennison Montgomery				2. DATE OF DEATH MONTH DAY YEAR Nov. 11, 1995		3. TIME OF DEATH 3:00A M	
4. SOCIAL SECURITY NUMBER 212-01-3544		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-03-1916	
9a. FACILITY NAME (If not institution, give street and number) 666 Chesapeake Drive				9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace		9c. COUNTY OF DEATH Harford	
10a. STATE MD				10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Havre de Grace	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 666 Chesapeake Drive			
10f. ZIP CODE 21078				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chief, Automotive Branch		16b. KIND OF BUSINESS/INDUSTRY Federal Government	
17. FATHER'S NAME (First, Middle, Last) Robert Gibson Montgomery				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Heffner			
19a. INFORMANT'S NAME (Type/Print) Mrs. Norma S. Montgomery				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 666 Chesapeake Dr., Havre de Grace, MD 21078			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Angel Hill Cemetery		DATE 11/14		20c. LOCATION — City or Town, State Havre de Grace, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Squamous Cell carcinoma of skin to metastasize to CNS DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 2 years Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 027154		29d. DATE SIGNED (Month, Day, Year) Nov. 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Louis Silverstein, M.D., P. O. Box 8, Havre de Grace, MD 21078 939-5843							
31. DATE FILED (Month, Day, Year) NOV 9 1995		32. REGISTRAR'S SIGNATURE 					

NOV 13 1995 John Davidson Randall

OHMM-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760
 BALTIMORE, MARYLAND 21215-0020
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1715

95 36172

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) CHARLES MC MANUS JR.				2. DATE OF DEATH MONTH NOVEMBER DAY 8 YEAR 1995		3. TIME OF DEATH 1:50 P.M.		
4. SOCIAL SECURITY NUMBER 178 22 2372		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 4, 1927		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's		
RESIDENCE OF DECEDENT								
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bowie		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 12907 Kendale Lane				10f. ZIP CODE 20715		10g. CITIZEN OF WHAT COUNTRY? United States		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 3 College (1-4 or 5+) 3				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Political Consultant		16b. KIND OF BUSINESS/INDUSTRY Government		
17. FATHER'S NAME (First, Middle, Last) Charles A. McManus, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Romanoski				
19a. INFORMANT'S NAME (Type/Print) Catherine P. McManus				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12907 Kendale Lane Bowie Md. 20715				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cemetery 11/13/95		20c. LOCATION — City or Town, State Clinton Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres.				22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Hemorrhage								
DUE TO (OR AS A CONSEQUENCE OF):								
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Hypertension								
DUE TO (OR AS A CONSEQUENCE OF):								
DUE TO (OR AS A CONSEQUENCE OF):								
DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER Leonard P. Appel M.D.				29c. LICENSE NUMBER D 00360		29d. DATE SIGNED (Month, Day, Year) 11/8/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LEONARD P. APPEL, M.D. 3231 Superior La. Bowie Md 20715								
31. DATE OF DEATH (Month, Day, Year) NOV 11 1995								

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or date, located near the bottom center of the page.

95 36173

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN W MEREDITH				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 8, 1995		3. TIME OF DEATH 10:45 PM	
4. SOCIAL SECURITY NUMBER 227-36-9171		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 1, 1931	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY	
9c. COUNTY OF DEATH PRINCE GEORGE'S				10a. STATE MARYLAND			
10b. COUNTY PRINCE GEORGE'S		10c. CITY, TOWN OR LOCATION CAPITOL HEIGHTS		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 7027 CANYON DRIVE	
10f. ZIP CODE 20743		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES ARMY 8/21/52-8/20/54	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 YRS.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BRICK MASON	
16b. KIND OF BUSINESS/INDUSTRY PRIVATE		17. FATHER'S NAME (First, Middle, Last) JESSIE PERSON		18. MOTHER'S NAME (First, Middle, Maiden Surname) ARISTABELLE PERSON		19a. INFORMANT'S NAME (Type/Print) JOHN K. MEREDITH/ SON	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 987 CENTRAL HILLS LANE LANDOVER, MD20785		20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK 11-11-95 LANDOVER, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Juanita L. Blaxton</i>		22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD. LANDOVER, MD20785		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive Heart Failure</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):		Approximate interval Between Onset and Death <i>months</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIED BY: 1 <input checked="" type="checkbox"/> CENSUS TAKING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
30. SIGNATURE AND TITLE OF CERTIFIER <i>Surinder Singh M.D.</i>				29c. LICENSE NUMBER D28920		29d. DATE SIGNED (Month, Day, Year) 11/9/95	
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Hardell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36174

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert F. McDonald				2. DATE OF DEATH MONTH DAY YEAR November 5, 1995				3. TIME OF DEATH 8:42 AM	
4. SOCIAL SECURITY NUMBER 108 12 6528		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 19, 1923		8. BIRTHPLACE (State or Foreign Country) New York	
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis				9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bowie				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2922 Tarragon Lane				10f. ZIP CODE 20715		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Analyst			16b. KIND OF BUSINESS/INDUSTRY U.S. Government		
17. FATHER'S NAME (First, Middle, Last) Daniel F. McDonald				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna L. Swift					
19a. INFORMANT'S NAME (Type/Print) Barbara J. McDonald				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2922 Tarragon Lane Bowie Maryland 20715					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart Church Cemetery			20c. LOCATION — City or Town, State 11/8/95 Bowie Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans, Pres.				22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Respiratory failure DUE TO (OR AS A CONSEQUENCE OF): b. Pulmonary Edema DUE TO (OR AS A CONSEQUENCE OF): c. Myocardial infarct-on DUE TO (OR AS A CONSEQUENCE OF): d. Cardiogenic Shock								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Elizabeth M. Kingsley MD						29c. LICENSE NUMBER D 22507		29d. DATE SIGNED (Month, Day, Year) 11-5-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elizabeth M. Kingsley M.D. 275 West Street Annapolis Md. 21401									
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE Jane A. [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36175

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John W. McAleer				2. DATE OF DEATH MONTH DAY YEAR October 30, 1995		3. TIME OF DEATH 10:05 p.m.	
4. SOCIAL SECURITY NUMBER 185 14 9127		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 24 1922	
9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Odenton		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2318 Golden Chapel Rd.				10f. ZIP CODE 21113		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Route Salesman		15b. KIND OF BUSINESS/INDUSTRY Sketchly Linen			
17. FATHER'S NAME (First, Middle, Last) Michael McAleer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nancy Bolger			
19a. INFORMANT'S NAME (Type/Print) Margaret McAleer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2318 Golden Chapel Rd. Odenton Maryland 21113			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 11/3/95		20c. LOCATION — City or Town, State Brentwood Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres.				22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → HEPATIC ENCEPHALOPATHY a. DUE TO (OR AS A CONSEQUENCE OF): CIRRHOSIS OF THE LIVER b. DUE TO (OR AS A CONSEQUENCE OF): ANEMIA c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1 week
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year) 		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED 	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER APRIL DEERMAN MORGAN HOME OFFICER				29c. LICENSE NUMBER D43977		29d. DATE SIGNED (Month, Day, Year) Oct 30 '95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) APRIL DEERMAN 301 HOSP. DRIVE GLEN BURNIE MD 20612							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE John Arundel Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36176

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WALTER MAHONE				2. DATE OF DEATH MONTH DAY YEAR November 10, 1995		3. TIME OF DEATH 9:15 P M	
4. SOCIAL SECURITY NUMBER 577-05-3452		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 99 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 18, 1896	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Golden Oaks Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Laurel	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Cheverly				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 5608 Hawthorne Street	
10f. ZIP CODE 20785				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter-Wallpaper		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Mary M. Short				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2008 Adkins Road Richmond, VA 23236			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 11/14, 1995		20c. LOCATION — City or Town, State Brentwood, MD		20d. DATE 11/14, 1995	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.B. Geier				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Hypertension							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D35430		29d. DATE SIGNED (Month, Day, Year) 11/13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Margolis MD 14333 Laurel Blume Rd #307 Laurel, MD 20708							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36177

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PATRICK JAMES MURRAY				2. DATE OF DEATH MONTH DAY YEAR 11 14 1995		3. TIME OF DEATH 4: 45 am M	
4. SOCIAL SECURITY NUMBER 186-16-4436		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 21, 1910	
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Lanham	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 6426 Tiffany Court				10f. ZIP CODE 20706		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Trainman		16b. KIND OF BUSINESS/INDUSTRY Railroad	
17. FATHER'S NAME (First, Middle, Last) John Francis Murray				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bridget Kittrick			
19a. INFORMANT'S NAME (Type/Print) Frances H. Murray				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6426 Tiffany Court Lanham, Maryland 20706			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Mary's Cemetery 11/17/1995		20c. LOCATION — City or Town, State Wilkes-Barre, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles F. Bell</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerosis							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
1. Acute appendicitis DUE TO (OR AS A CONSEQUENCE OF): 2. acute renal failure DUE TO (OR AS A CONSEQUENCE OF): 3. DUE TO (OR AS A CONSEQUENCE OF): 4. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Noninsulin Dependent Diabetes Mellitus							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D27865		29d. DATE SIGNED (Month, Day, Year) 11/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARK K LI 1721 University Blvd W, Wheaton MD 20902							
31. DATE FILED (Month, Day, Year) NOV 15 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36178

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) NATHANIEL MARTIN, JR.				2. DATE OF DEATH MONTH DAY YEAR Nov. 12, 1995		3. TIME OF DEATH 1 P.	
4. SOCIAL SECURITY NUMBER 235-62-8867		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 3, 1940	
9a. FACILITY NAME (If not institution, give street and number) MANOR CARE FERNWOOD				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE District		10b. COUNTY of Columbia		10c. CITY, TOWN OR LOCATION Washington		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3532 Highwood Drive S.E.				10f. ZIP CODE 20020		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 2-26-59/2-25-63		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Newspaper Distributor		16b. KIND OF BUSINESS/INDUSTRY Self Employed			
17. FATHER'S NAME (First, Middle, Last) Nathaniel Martin, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Daisy Haskins			
19a. INFORMANT'S NAME (Type/Print) Lynda M. Martin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3532 Highwood Dr. S.E., Wash. D.C. 20020			
20a. MANNER OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lee's Crematorium Nov. 14, 1995 Clinton, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John T. Stewart, II</i>				22. NAME AND ADDRESS OF FACILITY STEWART FUNERAL HOME 4001 Benning Rd. N.E. Wash. D.C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lymphoma, Metastatic DUE TO (OR AS A CONSEQUENCE OF): b. Lymphoma Of Sinuses, Lymphoid Malignancy DUE TO (OR AS A CONSEQUENCE OF): c. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. Due to (OR AS A CONSEQUENCE OF):						Approximate interval Between Onset and Death 3 months 4 months	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. H.I.V., Chronic Pernicious Anemia Chronic Obstructive Lung Disease						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28. DATE OF INJURY (Month, Day, Year) Nov. 12, 1995	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. Stewart, II</i> Physician		29c. LICENSE NUMBER D04686	
29d. DATE SIGNED (Month, Day, Year) Nov. 13, 1995				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert F. Dyer, M.D. 5530 Wisconsin Avenue, Chevy Chase, Md. 20815			
31. DATE FILED (Month, Day, Year) NOV 15 1995				32. REGISTRAR'S SIGNATURE <i>John T. Stewart, II</i>			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten signature and date: 10/10/10

95 36179

Amended #18, 11/14/95, MRT, Montgomery County
 FOR
 1 - STATE REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Karilyn Elizabeth Newman				2. DATE OF DEATH MONTH DAY YEAR November 11, 1995		3. TIME OF DEATH 5:35 AM	
4. SOCIAL SECURITY NUMBER 218-38-0766		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 16, 1907	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 211 Russell Avenue #710			
10f. ZIP CODE 20877				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 1/2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Not Available Pintarelli				18. MOTHER'S NAME (First, Middle, Maiden Surname) Myfawny W. Biondolillo Biondolillo			
19a. INFORMANT'S NAME (Type/Print) Karil Newman Hammer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9401 Duxford Court Potomac, Maryland 20854			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. November 12, 1995		20c. LOCATION — City or Town, State Bethesda, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara Jo McMillen Lawrence</i> M00831				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anoxic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF): b. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): c. Cerebral Vascular DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's Disease							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christopher Crawford</i>				29c. LICENSE NUMBER 031839		29d. DATE SIGNED (Month, Day, Year) November 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christopher Crawford 615 West Montgomery Ave. Rockville, MD 20850							
31. DATE FILED (Month, Day, Year) NOV 14 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

20

95 36180

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Doris Mae Norton				2. DATE OF DEATH MONTH DAY YEAR Nov - 10 95		3. TIME OF DEATH 3:48 PM	
4. SOCIAL SECURITY NUMBER 577-32-8921		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 21, 1925	
8. BIRTHPLACE (State or Foreign Country) Washington, DC				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1903 Stanley Avenue	
10f. ZIP CODE 20851				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Not Available				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jenny Ashton			
19a. INFORMANT'S NAME (Type/Print) Laura L. Norton-Ginow				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2 Box 330, Camdenton, Missouri 65020			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Nov. 15, 1995 Parklawn Memorial Park		20c. LOCATION — City or Town, State Rockville, Maryland		20d. DATE Nov. 15, 1995	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Randy Smith</i> M00198				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute myo cardiac infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate interval between Onset and Death 25 mins	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Tauber</i>				29c. LICENSE NUMBER 208546		29d. DATE SIGNED (Month, Day, Year) Nov. 10 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Tauber 8218 Wisconsin Ave Bethesda Md.							
31. DATE FILED (Month, Day, Year) NOV 16 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36181

Amended # 6, 11/16/95, MRT, Montgomery County

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Joseph Edward Nicholson				2. DATE OF DEATH MONTH DAY YEAR Nov. 15 1995		3. TIME OF DEATH 7:40 a.m.	
4. SOCIAL SECURITY NUMBER 703-07-9930		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 4, 1926	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital			
10. CITY, TOWN OR LOCATION OF DEATH Takoma Park				11. COUNTY OF DEATH Montgomery			
12. STATE Maryland		13. COUNTY Howard		14. CITY, TOWN OR LOCATION Columbia		15. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
16. STREET AND NUMBER 10799 Hickory Ridge Rd,				17. ZIP CODE 21044		18. CITIZEN OF WHAT COUNTRY? U.S.A.	
19. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War #2		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: Black	
23. DECEDENT'S EDUCATION (Specify only highest grade completed) 6th Grade		24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cobbler		25. KIND OF BUSINESS/INDUSTRY (Shoe Repair)			
26. FATHER'S NAME (First, Middle, Last) Joseph Nicholson				27. MOTHER'S NAME (First, Middle, Maiden Surname) Irene Wallace			
28. INFORMANT'S NAME (Type/Print) (Wife) Mrs Evelyn L. Nicholson				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10700 Cordage Walk, Columbia, Md #21044			
30. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cem. 11/20 Crownsville, Md		32. DATE 11/20		33. LOCATION — City or Town, State Crownsville, Md	
34. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				35. NAME AND ADDRESS OF FACILITY Snowden Funeral Home P.A 20850 246 N. Washington St. Rockville, Md			
36. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → sepsis a. DUE TO (OR AS A CONSEQUENCE OF): pneumonia b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic renal failure coronary artery disease							
38. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				39. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		40. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
41. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		42. 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
43. 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		44. 28a. DATE OF INJURY (Month, Day, Year)		45. 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> NO		46. 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
47. 28d. DESCRIBE HOW INJURY OCCURRED		48. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		49. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
50. 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
51. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Hyun H.O.</i>				52. 29c. LICENSE NUMBER 024283		53. 29d. DATE SIGNED (Month, Day, Year) 11.15.95	
54. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. YUSUF 3450 FORT MEADE ROAD LAUREL, MD. 20707							
55. 31. DATE FILED (Month, Day, Year) NOV 16 1995		56. 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36182

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CARL RAYMOND NICHOLS				2. DATE OF DEATH NOV. 14, 1995		3. TIME OF DEATH 11:50 p.m.	
4. SOCIAL SECURITY NUMBER 232-34-4386		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) December 14, 1928	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Fort Washington Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Fort Washington	
9c. COUNTY OF DEATH Prince George				10a. STATE Maryland		10b. COUNTY Charles	
10c. CITY, TOWN OR LOCATION Indian Head				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 130 Circle Ave.	
10f. ZIP CODE 20640				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) Foreman-High Voltage Lineman			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) U.S. Government				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Luther F. Nichols				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gladys E. Wheatcraft			
19a. INFORMANT'S NAME (Type/Print) Betty Lou Nichols				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Floral Hill Gardens of Memory November 20, 1995			
20c. LOCATION — City or Town, State Pocotalico, West Virginia				21. SIGNATURE OF FUNERAL SERVICE LICENSEE MO0668			
22. NAME AND ADDRESS OF FACILITY Williams Funeral Home, P.A. Rt. 225 & Glymont Rd., Indian Head, Md. 20640				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic Infarction of Small Bowel DUE TO (OR AS A CONSEQUENCE OF): b. Hypertension-Malignant DUE TO (OR AS A CONSEQUENCE OF): c. Atrial Fibrillation DUE TO (OR AS A CONSEQUENCE OF): d. Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Amir Mirza-Alikhani				29c. LICENSE NUMBER D 46046		29d. DATE SIGNED (Month, Day, Year) 11/15/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Amir Mirza-Alikhani 11711 Livingston Rd. Ft. Wash., MD 20744							
31. DATE FILED (Month, Day, Year) NOV 20 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject.

2. The second part of the report is a detailed description of the methods used.

3. The third part of the report is a discussion of the results obtained.

4. The fourth part of the report is a conclusion.

5. The fifth part of the report is a list of references.

6. The sixth part of the report is a list of figures.

7. The seventh part of the report is a list of tables.

8. The eighth part of the report is a list of appendices.

95 36183

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Catherine Olayos				2. DATE OF DEATH MONTH DAY YEAR Nov 8 1995		3. TIME OF DEATH 2 A M	
4. SOCIAL SECURITY NUMBER 578-12-3802		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 18, 1910	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Prince George	
10c. CITY, TOWN OR LOCATION Adelphi				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1801 Metzert Road	
10f. ZIP CODE 20783				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY United States Government	
17. FATHER'S NAME (First, Middle, Last) Michael Creegan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Steakem			
19a. INFORMANT'S NAME (Type/Print) Paul F. Schlegel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7440 Morgan Road, Woodbine, Maryland 21797			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. November 15, 1995		20c. LOCATION — City or Town, State Bethesda, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara J. McMullen Lawrence</i> MO0831				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Sepsis</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>Acute renal failure</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>Volume depletion</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Approximate interval between Onset and Death 24° 24° 1 week							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D41931		29d. DATE SIGNED (Month, Day, Year) Nov 8, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R Shonachen MD 2309 Shorefield Rd Wheat 20902							
31. DATE FILED (Month, Day, Year) NOV 14 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36184

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John R. O'Hagan				2. DATE OF DEATH MONTH November DAY 10 YEAR 1995		3. TIME OF DEATH 10:54P.M.	
4. SOCIAL SECURITY NUMBER 219-82-5155		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 34 YRS.		7. DATE OF BIRTH (Month, Day, Year) September 26, 1961	
9a. FACILITY NAME (If not institution, give street and number) Laurel Regional Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Laurel		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland				10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Laurel	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 8112 Elsie's Way			
10f. ZIP CODE 20723				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lineman		16b. KIND OF BUSINESS/INDUSTRY Pepco			
17. FATHER'S NAME (First, Middle, Last) James H. O'Hagan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Logan			
19a. INFORMANT'S NAME (Type/Print) Amy M. O'Hagan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 11/14/95 Silver Spring, Maryland		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harold V. Borgwardt</i>		22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705					
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUBARACHNOID HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): b. RUPTURED CEREBRAL ARTERY ANEURYSM DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Jutovich</i>				29c. LICENSE NUMBER D31089		29d. DATE SIGNED (Month, Day, Year) November 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MORRIS JUTOVICH, MD 8201 Corporate Drive, Suite 620, Landover, MD 20785							
31. DATE FILED (Month, Day, Year) NOV 17 1995		32. REGISTRAR'S SIGNATURE <i>John R. O'Hagan</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

9

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36185

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

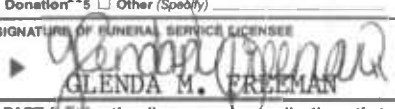
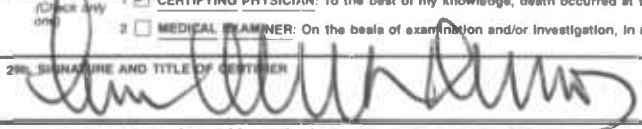
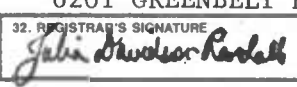
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VETRA GRAY OBERLE				2. DATE OF DEATH MONTH NOVEMBER DAY 11 YEAR 1995		3. TIME OF DEATH 8:40 A.M.	
4. SOCIAL SECURITY NUMBER 243-12-6763		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 20, 1912	
9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Fallston		9c. COUNTY OF DEATH Harford		8. BIRTHPLACE (State or Foreign Country) North Carolina	
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Bel Air		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1407 R Churchville Road		10f. ZIP CODE 21014		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (14 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY U. S. Government			
17. FATHER'S NAME (First, Middle, Last) George (u/k) Adams				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Lee Pardue			
19a. INFORMANT'S NAME (Type/Print) Le Alyce Garrett				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1407 Churchville Road, Bel Air, Md. 21014			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris & Co., Inc. 11/13/95 West Chester, PA		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Intracerebral Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): b. Coagulopathy DUE TO (OR AS A CONSEQUENCE OF): c. Acute Common Bile Duct Obstruction. DUE TO (OR AS A CONSEQUENCE OF): d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Coronary Artery Disease - Advanced Degenerative Disc Disease.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D35012		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 12, '95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Kevin Lynch MD. 2 NORTH AVE. BEL AIR, MD. 21014.							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

95 36186

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lionel Osborne				2. DATE OF DEATH MONTH November DAY 3 , YEAR 1995		3. TIME OF DEATH 9:30 A M	
4. SOCIAL SECURITY NUMBER 577-66-7247		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 47 YRS.		7. DATE OF BIRTH (Month, Day, Year) JANUARY 20, 48	
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH TAKOMA PARK		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE N/A				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION WASHINGTON, D.C.	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1106 - 4th STREET, N.E.			
10f. ZIP CODE 20002				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WELDER		16b. KIND OF BUSINESS/INDUSTRY PRIVATE			
17. FATHER'S NAME (First, Middle, Last) NOT AVAILABLE				18. MOTHER'S NAME (First, Middle, Maiden Surname) DOROTHY BLALOCK			
19a. INFORMANT'S NAME (Type/Print) EDWARD CARR (BROTHER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 - 4th STREET, N.E.; WASHINGTON, D.C. 20002			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) RIVERDALE CREMATORY 11/10/95		20c. LOCATION — City or Town, State RIVERDALE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  GLENDA M. FREEMAN				22. NAME AND ADDRESS OF FACILITY JOHNSON & JENKINS FUNERAL HOME, INC. 716 KENNEDY STREET, N.W.; WDC 20011			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Required immune deficiency syndrome a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. non-small cell lung cancer, pneumonia, hypertension Did tobacco use contribute to cause of death? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 801499		29d. DATE SIGNED (Month, Day, Year) Nov 3, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DENNIS LEWIS, M.D. 6201 GREENBELT ROAD UNIT #1 ; GREENBELT, MARYLAND							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36187

Amended #17, 11/14/95, MRT, Montgomery County
 FOR
 STATE
 REGISTRAR
 1 -
 STATE
 REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Letha E Pomeroy				2. DATE OF DEATH MONTH DAY YEAR November 9, 1995		3. TIME OF DEATH 11:20 A.M.	
4. SOCIAL SECURITY NUMBER 308-01-9561		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 8, 1909	
8. BIRTHPLACE (State or Foreign Country) Indiana				9a. FACILITY NAME (If not institution, give street and number) Sharon Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Sandy Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 15310 Beaverbrook Court	
10f. ZIP CODE 20906				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 6+) 1				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Executive Secretary		16b. KIND OF BUSINESS/INDUSTRY National Education Association	
17. FATHER'S NAME (First, Middle, Last) Bert C. Whitaker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lena M. Purvis			
19a. INFORMANT'S NAME (Type/Print) Edward C. Pomeroy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 15310 Beaverbrook Court Silver Spring, Maryland			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) November 11, 1995 Montgomery Crematorium, Inc.		20c. LOCATION — City or Town, State Bethesda, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] M00202				22. NAME AND ADDRESS OF FACILITY Robert A. Humphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → renal failure							
DUE TO (OR AS A CONSEQUENCE OF):							
Severely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
Severely dehydratation							
DUE TO (OR AS A CONSEQUENCE OF):							
pneumonia							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's disease							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] (Physician) (Attending)				29c. LICENSE NUMBER D42046			
29d. DATE SIGNED (Month, Day, Year) November 9, 1995				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G. BROOKE HUFFMAN, MD 18100 Slade School Rd Sandy Spring MD 20860			
31. DATE FILED (Month, Day, Year) NOV 14 1995				32. REGISTRAR'S SIGNATURE [Signature]			

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 36188

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY ELIZABETH POWELL				2. DATE OF DEATH MONTH DAY YEAR November 11, 1995		3. TIME OF DEATH 1236 A M	
4. SOCIAL SECURITY NUMBER 227-28-5172		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) 70 YRS.	7. DATE OF BIRTH (Month, Day, Year) May 19, 1925		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Westminister		9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 613 Black Drive				10f. ZIP CODE 20904		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cashier		16b. KIND OF BUSINESS/INDUSTRY Grocery Store/SuperFresh			
17. FATHER'S NAME (First, Middle, Last) Fred Simmons				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Wilfong			
19a. INFORMANT'S NAME (Type/Print) Kitty Knill				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Jill Court Reisterstown, MD 21136			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 11/14/95		20c. LOCATION — City or Town, State Suitland, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Janet L. Holland</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Ischemic CARDIOMYOPATHY a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate interval Between Onset and Death 2 years 5 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jan H. Schreibfeder MD</i>				29c. LICENSE NUMBER D28221		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAN H. SCHREIBFEDER, MD 200 MEMORIAL AVE WESTMINSTER MARYLAND							
31. DATE FILED (Month, Day, Year) NOV 15 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> 21157			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36189

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Raquel Parra				2. DATE OF DEATH MONTH DAY YEAR November 9, 1995		3. TIME OF DEATH 10:55 P M	
4. SOCIAL SECURITY NUMBER 214-41-4068		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 18, 1951	
8. BIRTHPLACE (State or Foreign Country) Colombia							
9a. FACILITY NAME (If not institution, give street and number) 11028 Powder Horn Drive				9b. CITY, TOWN OR LOCATION OF DEATH Potomac		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Potomac		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11028 Powder Horn Drive				10f. ZIP CODE 20854		10g. CITIZEN OF WHAT COUNTRY? Colombia	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Colombian		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nanny		16b. KIND OF BUSINESS/INDUSTRY Private Homes			
17. FATHER'S NAME (First, Middle, Last) Manuel Parra				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mercedes Vergara			
19a. INFORMANT'S NAME (Type/Print) Juan E. Allard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory		DATE 11-10		20c. LOCATION — City or Town, State Beltsville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ellen A. Rapp</i>				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC LEIOMYOSARCOMA OF THE UTERUS DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 3 MOS.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Victor Priego MD</i>				29c. LICENSE NUMBER 023308		29d. DATE SIGNED (Month, Day, Year) November 10, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Victor M. Priego, M. D., 11420 Rockville Pike, #20, Rockville, MD 20852-3006							
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE <i>Johi Anderson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.



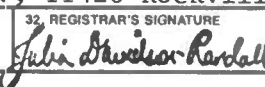
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36190

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Victor Ernesto Perozzi				2. DATE OF DEATH MONTH DAY YEAR November 12, 1995		3. TIME OF DEATH 2:09 A. M	
4. SOCIAL SECURITY NUMBER 212-21-8929		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 50 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) May 26, 1945	
8. BIRTHPLACE (State or Foreign Country) Argentina				9a. FACILITY NAME (If not institution, give street and number) 19640 Rhinestone Drive		9b. CITY, TOWN OR LOCATION OF DEATH Germantown	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Germantown				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 19640 Rhinestone Drive	
10f. ZIP CODE 20874		10g. CITIZEN OF WHAT COUNTRY? Argentina		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Argentine				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Automobile Upholsterer		16b. KIND OF BUSINESS/INDUSTRY Automobile Industry			
17. FATHER'S NAME (First, Middle, Last) Alberto Perozzi				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosario Costanzo			
19a. INFORMANT'S NAME (Type/Print) Elena S. Perozzi				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19640 Rhinestone Dr., Germantown, MD 20874			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory		DATE 11/14		20c. LOCATION — City or Town, State Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY De Vol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Renal Cell Carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 9 months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D23308		29d. DATE SIGNED (Month, Day, Year) Nov. 13, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Victor Priego, M.D., 11420 Rockville Pike #20, Rockville, Maryland 20852							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36191

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROY Leon PAUGH				2. DATE OF DEATH MONTH NOVEMBER DAY 11 YEAR 1995		3. TIME OF DEATH 0720 A.M.	
4. SOCIAL SECURITY NUMBER 234-42-7575		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 66 YRS.	7. DATE OF BIRTH (Month, Day, Year) Feb. 16, 1929		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7092 Catalpa Road				10f. ZIP CODE 21703		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean War		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Meat Buyer		16b. KIND OF BUSINESS/INDUSTRY Retail Food			
17. FATHER'S NAME (First, Middle, Last) Arthur Paugh				18. MOTHER'S NAME (First, Middle, Maiden Surname) Tina Nelson			
19a. INFORMANT'S NAME (Type/Print) Doris Paugh				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7092 Catalpa Road, Frederick, Maryland 21703			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 11/15		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edmund A. Gugger</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → multiple myeloma DUE TO (OR AS A CONSEQUENCE OF): a. multiple myeloma b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1yr
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure, Hypotension Anoxic Encephalopathy							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Peter B. Sherer MD</i>				29c. LICENSE NUMBER 021910		29d. DATE SIGNED (Month, Day, Year) November 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter B. Sherer MD 3947 Ferrara Dr Wheaton, MD 20906							
31. DATE FILED (Month, Day, Year) NOV 14 1995		32. REGISTRAR'S SIGNATURE <i>Jahia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36192

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Josephine E. Phipps				2. DATE OF DEATH MONTH DAY YEAR November 13, 1995		3. TIME OF DEATH 0848 A.M.	
4. SOCIAL SECURITY NUMBER 577-09-1239		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	7. DATE OF BIRTH (Month, Day, Year) Dec. 28, 1911	8. BIRTHPLACE (State or Foreign Country) Washington, DC		
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 927 Lewis Avenue				10f. ZIP CODE 20851		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) John T. Pearson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie E. Dean			
19a. INFORMANT'S NAME (Type/Print) Milton R. Phipps, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12405 Hickory Tree Way, F, Germantown, MD 20874			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery Nov. 16, 1995		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Randy Ford</i>		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>acute myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death Minutes	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF):				Years	
		c. <i>/</i> DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>hypertension</i> <i>peripheral vascular disease</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M.O.</i>				29c. LICENSE NUMBER D 37024		29d. DATE SIGNED (Month, Day, Year) November 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID G. SPOUR 9901 Medical Center Drive, Rockville, Maryland 20850							
31. DATE FILED (Month, Day, Year) NOV 17 1995		32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #10b,10d, 17,18 11/23/95, MRT, Montgomery County

95 36193

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANN C. PEEBLES				2. DATE OF DEATH MONTH DAY YEAR NOV. 10, 1995				3. TIME OF DEATH 12:40 PM	
4. SOCIAL SECURITY NUMBER 212-39-5117		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 28, 1903		8. BIRTHPLACE (State or Foreign Country) ANTIGUA, W. INDIES	
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING				9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MD.				10b. COUNTY HOWARD PRINCE GEORGES		10c. CITY, TOWN OR LOCATION LAUREL			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 10364 STANSFIELD RD.		10f. ZIP CODE 20723		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY AT HOME					
17. FATHER'S NAME (First, Middle, Last) THOMAS WILLIAM WILLIAMS				18. MOTHER'S NAME (First, Middle, Maiden Surname) HENRIETTA McKAY					
19a. INFORMANT'S NAME (Type/Print) SAMUEL W. PEEBLES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND NATIONAL CEMETERY 11/18 LAUREL, MD.		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.W. Chambers M00091				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. DEHYDRATION DUE TO (OR AS A CONSEQUENCE OF): c. DEMENTIA DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 1 month 2 months	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER G. Thaler MD		29c. LICENSE NUMBER D43430		29d. DATE SIGNED (Month, Day, Year) November, 13, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 18111 Prince Philip Dr 212 01-my MD GAURANG THAKER M.D. 20832									
31. DATE FILED (Month, Day, Year) NOV 16 1995				32. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9 10 11

95 36194

Amended item #1 per F.D. 11/20/95 Carroll Co. P.L.C.
 FOR
 STATE
 REGISTRAR
 1 -
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>BABY BOY Stephen Michael Logan Pickett GAMBER</u>				2. DATE OF DEATH MONTH DAY YEAR <u>NOVEMBER 16, 1995</u>		3. TIME OF DEATH <u>9:04 P M</u>	
4. SOCIAL SECURITY NUMBER <u>N/A</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS <u>3</u>		7. DATE OF BIRTH (Month, Day, Year) <u>NOV. 13, 1995</u>	
8a. FACILITY NAME (If not institution, give street and number) <u>THE JOHNS HOPKINS HOSPITAL</u>				8b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE CITY</u>		8c. COUNTY OF DEATH <u>MARYLAND</u>	
9a. RESIDENCE OF DECEDENT 10a. STATE <u>MARYLAND</u> 10b. COUNTY <u>CARROLL</u> 10c. CITY, TOWN OR LOCATION <u>TANEYTOWN</u> 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>1 COURTLAND STREET</u> 10f. ZIP CODE <u>21787</u> 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>CAUCASIAN</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>N/A</u> College (1-4 or 5+) <u>N/A</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>N/A</u>		16b. KIND OF BUSINESS/INDUSTRY <u>N/A</u>			
17. FATHER'S NAME (First, Middle, Last) <u>JOSEPH CLIFTON MERLE PICKETT, Sr.</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>JACQUELINE MARIE GAMBER</u>			
19a. INFORMANT'S NAME (Type/Print) <u>JOSEPH C. M. PICKETT, SR.</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1 COURTLAND STREET TANEYTOWN, MARYLAND 21787</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>TRINITY LUTHERAN CEMETERY 11/20</u>		20c. LOCATION — City or Town, State <u>TANEYTOWN, MARYLAND</u>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>P. Kevin Judy</u>	
22. NAME AND ADDRESS OF FACILITY <u>SKILES FUNERAL HOME TANEYTOWN, MD 21787</u>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Triploidy 69 xxy</u> DUE TO (OR AS A CONSEQUENCE OF): <u>b. Severe Intrauterine growth retardation</u> DUE TO (OR AS A CONSEQUENCE OF): <u>c. Multiple congenital Anomalies.</u> DUE TO (OR AS A CONSEQUENCE OF): <u>d.</u>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Madeleine Jan (Faculty, Pediatrics)</u>				29c. LICENSE NUMBER <u>106087</u>		29d. DATE SIGNED (Month, Day, Year) <u>November 16, '95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MADHU NIGAM CMC 210, JOHNS HOPKINS HOSPITAL.</u>							
31. DATE FILED (Month, Day, Year) <u>NOV 20 1995</u>				32. REGISTRAR'S SIGNATURE <u>Jane D. Jackson-Randall</u>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 36195

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edward John Plourde, Jr.				2. DATE OF DEATH MONTH DAY YEAR November 16, 1995		3. TIME OF DEATH 3:05 A.M.	
4. SOCIAL SECURITY NUMBER 047-22-3382		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 25, 1931	
8. BIRTHPLACE (State or Foreign Country) Connecticut				9a. FACILITY NAME (If not institution, give street and number) 12308 Chado Court		9b. CITY, TOWN OR LOCATION OF DEATH Clinton	
9c. COUNTY OF DEATH Prince George				10a. STATE Maryland		10b. COUNTY Prince George	
10c. CITY, TOWN OR LOCATION Clinton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 12308 Chado Court	
10f. ZIP CODE 20735				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1949-1968				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electronic Engineer		16b. KIND OF BUSINESS/INDUSTRY Electronics	
17. FATHER'S NAME (First, Middle, Last) Edward John Plourde, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dora Plourde			
19a. INFORMANT'S NAME (Type/Print) Anna L. Plourde				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12308 Chado Court Clinton, MD 20735			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 11/17		20c. LOCATION — City or Town, State Alexandria, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00817 <i>Rayton C. Echols III</i>				22. NAME AND ADDRESS OF FACILITY Arehart-Echols Funeral Home, Inc. P.O. Box 567 La Plata, MD 20646			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martin D. Weitz</i>				29c. LICENSE NUMBER D23743		29d. DATE SIGNED (Month, Day, Year) 11/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTIN D. WEITZ 7515 Greenway Ct One Greenbelt MD 20770							
31. DATE FILED (Month, Day, Year) NOV 20 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36196

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Hanna Agnes Pipberger				2. DATE OF DEATH MONTH DAY YEAR November 15, 1995		3. TIME OF DEATH 10:45 P M	
4. SOCIAL SECURITY NUMBER 561-50-4534		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2/27/23	
8. BIRTHPLACE (State or Foreign Country) Bulgaria				9. COUNTY OF DEATH Prince George's			
9a. FACILITY NAME (If not institution, give street and number) 10929 Mariner St.				9b. CITY, TOWN OR LOCATION OF DEATH Ft. Washington		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Ft. Washington	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 10929 Mariner St.				10f. ZIP CODE 20744		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Medical Research Assist.		16b. KIND OF BUSINESS/INDUSTRY Federal Government			
17. FATHER'S NAME (First, Middle, Last) Albert Zulauf				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Arquint			
19a. INFORMANT'S NAME (Type/Print) George Zulauf				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holhwangstrasse 7304 Maienfeld Switzerland			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 11/16/95		20c. LOCATION — City or Town, State Alexandria, Va.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i>				22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung cancer a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1 year
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William T. Tanner M.D.				29c. LICENSE NUMBER D35206		29d. DATE SIGNED (Month, Day, Year) 11/16/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William T. Tanner, M.D. 11701 Livingston Rd. Ft. Washington, Md. 20744							
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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Handwritten text at the bottom of the page, possibly a signature or date.

95 36197

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GERALDINE PLUMBER		2. DATE OF DEATH MONTH NOVEMBER DAY 4 YEAR 1995		3. TIME OF DEATH 7.32P M
4. SOCIAL SECURITY NUMBER 259-88-3563	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 51 YRS.	7. DATE OF BIRTH (Month, Day, Year) July 31, 1944	8. BIRTHPLACE (State or Foreign Country) Anderson Co South Carolina
9a. FACILITY NAME (If not institution, give street and number) Prince George's General Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's
RESIDENCE OF DECEDENT				
10a. STATE Virginia	10b. COUNTY Fairfax County	10c. CITY, TOWN OR LOCATION Alexandria		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 6618 Indian Trail Court		10f. ZIP CODE 22310		10g. CITIZEN OF WHAT COUNTRY? United States of America
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Not Available		16b. KIND OF BUSINESS/INDUSTRY Hotel
17. FATHER'S NAME (First, Middle, Last) Parris Plumber		18. MOTHER'S NAME (First, Middle, Maiden Surname) Christina Bell		
19a. INFORMANT'S NAME (Type/Print) Ruby Hunter		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Charles Reed Road, Starr, South Carolina		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cemetery Pleasant Grove Baptist Church		20c. LOCATION — City or Town, State Starr, South Carolina
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Howard A. Cousen #M00690		22. NAME AND ADDRESS OF FACILITY Unity Mortuary 401 S. Fant Street, Anderson, SC 29624		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Sarcoma DUE TO (OR AS A CONSEQUENCE OF): b. Gastrointestinal bleeding DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death 15 months 1 day
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER Harry J. Kiefer MD		29c. LICENSE NUMBER D20352		29d. DATE SIGNED (Month, Day, Year) 11/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H. Katzen, M.D. 8926 Woodyard Road, Clinton, MD 20735				
31. DATE FILED (Month, Day, Year) NOV 17 1995		32. REGISTRAR'S SIGNATURE John D. ...		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOV 15 1932

95 36198

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

12 2/10

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) DAVID PERKINS				2. DATE OF DEATH MONTH 11 DAY 12 YEAR 95		3. TIME OF DEATH 850 P M	
4. SOCIAL SECURITY NUMBER 578-50-3677		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 21 1938	
8. BIRTHPLACE (State or Foreign Country) Washington, GA				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring, MD	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Prince Georges	
10c. CITY, TOWN OR LOCATION Fairmont Heights, Maryland				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 5505 K Street	
10f. ZIP CODE 20743				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 11/10/55 - 7/29/59				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance		16b. KIND OF BUSINESS/INDUSTRY U.S. Postal Service	
17. FATHER'S NAME (First, Middle, Last) John W. Perkins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Daisy Moss			
19a. INFORMANT'S NAME (Type/Print) Mark Perkins (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2910 Madeira Court Woodbridge, VA 22192			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD State Veterans 11/17		20c. LOCATION — City or Town, State Cheltenham, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex. S. Pope Jr.</i>				22. NAME AND ADDRESS OF FACILITY Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD 20747			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 30 minutes
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMOTHORAX COPD							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							24c. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alex. S. Pope Jr. MD</i>				29c. LICENSE NUMBER D-25914		29d. DATE SIGNED (Month, Day, Year) 11-12-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALLEN BRINER, MD 12201 PLUM ORCHARD DRIVE, COLESVILLE, MARYLAND 2080							
31. DATE FILED (Month, Day, Year) NOV 17 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randolph</i>			

THE
OFFICE OF THE
SECRETARY OF THE
NAVY
WASHINGTON, D. C.
JAN 10 1900

95 36199

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ETHEL LEE PATTERSON				2. DATE OF DEATH MONTH OCT DAY 30 YEAR 1995		3. TIME OF DEATH 10:09 A M	
4. SOCIAL SECURITY NUMBER 244-34-5313		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) December 7, 1913	
9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 14100 Whispering Pines Court #32				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (14 or 5+) Domestic		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		15b. KIND OF BUSINESS/INDUSTRY Private			
17. FATHER'S NAME (First, Middle, Last) Jacob Jones				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rebecca Hayes			
19a. INFORMANT'S NAME (Type/Print) Mary L. General (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14100 Whispering Pines Ct. #32 Silver Spring, Md 20906			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Riverdale Park Crematory 11/9/95 Riverdale, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Belva J. Jenkins				22. NAME AND ADDRESS OF FACILITY Johnson & Jenkins Inc. 716 Kennedy St., N.W. Wash. D.C. 20011			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 day							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Amendur MP				29c. LICENSE NUMBER D38262		29d. DATE SIGNED (Month, Day, Year) October 31, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MURITA MENDIRATTA 2401 Research Blvd Rockville MD 20854							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE John Andrew Marshall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

4

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100

95 36200

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ladine Hackney Rever				2. DATE OF DEATH MONTH DAY YEAR November 13, 1995		3. TIME OF DEATH 9:25 PM	
4. SOCIAL SECURITY NUMBER 511-09-3767		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 25, 1910	
9a. FACILITY NAME (If not institution, give street and number) Manor Care Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION College Park		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6911 Dartmouth Avenue				10f. ZIP CODE 20740		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Clarence Roy Hackney				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie Conway			
19a. INFORMANT'S NAME (Type/Print) Philip R. Rever				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Red Gate Court, Silver Spring, Maryland 20905			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Crematory 11/15		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Philip R. Rever</i>		22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic heart disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Noninsulin dependent diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe dementia Hypothyroid							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Melissa B. Friedland</i>				29c. LICENSE NUMBER D32923		29d. DATE SIGNED (Month, Day, Year) 11/14/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Melissa B. Friedland 2415 Mungrove Rd #205 Silver Spring, MD 20904							
31. DATE FILED (Month, Day, Year) NOV 16 1995		32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36201

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BARBARA M. RABNER				2. DATE OF DEATH MONTH NOV DAY 07 YEAR 1995		3. TIME OF DEATH 0220 AM	
4. SOCIAL SECURITY NUMBER 577-30-2092		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 29, 1928	
8. BIRTHPLACE (State or Foreign Country) Illinois				9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rockville	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Potomac				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 10905 Balantre Lane	
10f. ZIP CODE 20854				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Real Estate Agent		16b. KIND OF BUSINESS/INDUSTRY Real Estate	
17. FATHER'S NAME (First, Middle, Last) Charles Milburn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ermina Stevens			
19a. INFORMANT'S NAME (Type/Print) John B. Rabner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10905 Balantre Lane Potomac, Maryland 20854			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. Nov. 9, 1995		20c. LOCATION — City or Town, State Bethesda, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] M00202				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphery Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Pneumonia, Left Lower LOBE							
DUE TO (OR AS A CONSEQUENCE OF):							
c. PULMONARY EMPHYSEMA							
DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature], M.D., F.C.C.P.				29c. LICENSE NUMBER 007067		29d. DATE SIGNED (Month, Day, Year) 11 8 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EDWARD S. MEHLMAN 5625 BRADLEY BOULEVARD BETHESDA, MARYLAND 20814							
31. DATE FILED (Month, Day, Year) NOV 14 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

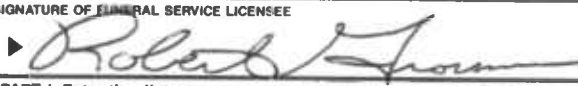

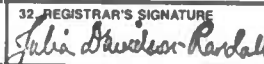
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36202

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) MORRIS REIF				2. DATE OF DEATH MONTH DAY YEAR NOV. 11, 1995		3. TIME OF DEATH 7:55 A M	
4. SOCIAL SECURITY NUMBER 065-18-1248		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 1, 1904	
8. BIRTHPLACE (State or Foreign Country) AUSTRIA				9. COUNTY OF DEATH MONTGOMERY			
9a. FACILITY NAME (If not institution, give street and number) CARRIAGE HILL Bethesda				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND				10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BETHESDA	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 5206 W. CEDAR LANE				10f. ZIP CODE 20814		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PERSONNEL		16b. KIND OF BUSINESS/INDUSTRY US POSTAL SERVICE			
17. FATHER'S NAME (First, Middle, Last) ABRAHAM ISAAC REIF				18. MOTHER'S NAME (First, Middle, Maiden Surname) ERNESTINE POSER			
19a. INFORMANT'S NAME (Type/Print) HARRIET GREENWALD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5206 W. CEDAR LANE-BETHESDA, MARYLAND 20814			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BETH EL		20c. LOCATION — City or Town, State WESTWOOD, NEW JERSEY		20d. DATE 11-13	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral vascular insufficiency							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER D11024		29d. DATE SIGNED (Month, Day, Year) 11/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John B. Umhoe, MD 8805 Conn. Ave. Chevy Chase Md. 20815							
31. DATE FILED (Month, Day, Year) NOV 15 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12

95 36203

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>CLAUDE Robbins</u>				2. DATE OF DEATH MONTH DAY YEAR <u>November 8 1995</u>		3. TIME OF DEATH <u>11:05 A M</u>	
4. SOCIAL SECURITY NUMBER <u>223-10-9651</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>82</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Oct. 26, 1913</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Harford Memorial Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Havre de Grace</u>		9c. COUNTY OF DEATH <u>Harford</u>	
10a. STATE <u>Maryland</u>				10b. COUNTY <u>Harford</u>		10c. CITY, TOWN OR LOCATION <u>Darlington</u>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <u>2406 Franklin Church Road</u>				10f. ZIP CODE <u>21034</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 8+) <u>0</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Builder</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Self employed</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Franklin Robbins</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Fannie Kirby</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Mrs. Patty S. Campbell</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>119 Meeks Drive, Aberdeen, Maryland 21001</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Pugh Cemetery (11-11-95)</u>		20c. LOCATION — City or Town, State <u>Teas, Virginia</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Mary R. DiGiovanni</u>				22. NAME AND ADDRESS OF FACILITY <u>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or suffocation. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Carcinoma of Gall bladder c Metastasis</u> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <u>Dehydration</u> DUE TO (OR AS A CONSEQUENCE OF):					
		c. <u>Malnutrition</u> DUE TO (OR AS A CONSEQUENCE OF):					
		d. <u>Renal failure</u> DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Anemia</u>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Bzug</u>				29c. LICENSE NUMBER <u>D43115</u>		29d. DATE SIGNED (Month, Day, Year) <u>11-8-95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MIRZA ABAIG MD</u>							
31. DATE FILED (Month, Day, Year) <u>NOV 9 1995</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

95 36204

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mamie Irene Remines				2. DATE OF DEATH MONTH DAY YEAR November 8, 1995		3. TIME OF DEATH 10:40 p^M	
4. SOCIAL SECURITY NUMBER 213-28-8297		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/12/1931	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 116 Rigdon Road		9b. CITY, TOWN OR LOCATION OF DEATH Aberdeen	
9c. COUNTY OF DEATH Harford				10a. STATE Maryland		10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Aberdeen				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 116 Rigdon Road	
10f. ZIP CODE 21001				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16. KIND OF BUSINESS/INDUSTRY In home			
17. FATHER'S NAME (First, Middle, Last) Russell V. Sexton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maude Marie Childers			
19a. INFORMANT'S NAME (Type/Print) Herbert H. Remines				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Rigdon Road, Aberdeen, MD 21001			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BelAir Memorial Gardens 11/11		20c. LOCATION — City or Town, State BelAir, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kirsten Amy Unglesbee				22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. EXTENSIVE METASTATIC GASTRIC CARCINOMA 6 months							
DUE TO (OR AS A CONSEQUENCE OF):							
b. MALIGNANT ASCITIS 6 months							
DUE TO (OR AS A CONSEQUENCE OF):							
c. CACHEXIA 6 months							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER MD				29c. LICENSE NUMBER D 31856		29d. DATE SIGNED (Month, Day, Year) 11/9/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D. SHARMA 1814 BELAIR RD FALLSTON MD 21047							
31. DATE FILED (Month, Day, Year) NOV 9 1995				32. REGISTRAR'S SIGNATURE Julia Shuster-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

40862

95 36205

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>John (nm) Remakis Jr.</i>				2. DATE OF DEATH MONTH <i>11</i> DAY <i>10</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>11:35 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>164-22-5898</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>67</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 6, 1928</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Harford Memorial Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Havre de Grace</i>	
9c. COUNTY OF DEATH <i>Harford</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Harford</i>	
10c. CITY, TOWN OR LOCATION <i>Bel Air</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>2804 Belcamp Road</i>	
10f. ZIP CODE <i>21015</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>1946-1972</i>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (8-12) 12</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Lieutenant Commander</i>		16b. KIND OF BUSINESS/INDUSTRY <i>U.S. Government</i>	
17. FATHER'S NAME (First, Middle, Last) <i>John (nm) Remakis, Sr.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Arabelle Ann Crispell</i>			
19a. INFORMANT'S NAME (Type/Print) <i>John Remakis III</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4219 Beverly Lane, Atlanta, Georgia 30342</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>R.A. Ferris & Co., Inc. 11/13/95</i>		20c. LOCATION — City or Town, State <i>West Chester, PA</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i>				22. NAME AND ADDRESS OF FACILITY <i>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>renal Ca</i> <i>prostate Ca</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Benner, M.D. physician</i>				29c. LICENSE NUMBER <i>D37697</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/10/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>M. Benner Harford Memorial Hospital</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 13 1995</i>				32. REGISTRAR'S SIGNATURE <i>Gail Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36206

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Agnes Richards</i>		2. DATE OF DEATH MONTH <i>November</i> DAY <i>14</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>11:44</i> M	
4. SOCIAL SECURITY NUMBER 182 20 9407		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.	
7a. FACILITY NAME (If not institution, give street and number) 3516 Maureen Lane		7b. CITY, TOWN OR LOCATION OF DEATH Bowie		7c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bowie	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 3516 Maureen Lane		10f. ZIP CODE 20715	
10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home		17. FATHER'S NAME (First, Middle, Last) Piet Vamderzouwem	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Cornealia Edzinga		19a. INFORMANT'S NAME (Type/Print) Edwin G. Richards		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24729 Williston Rd. Denton Maryland 21629	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sudlersville Cemetery 11/7/95		20c. LOCATION — City or Town, State Sudlersville Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Evans Pres</i>		22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augustine P. Branguez MD</i>		29c. LICENSE NUMBER <i>D31230</i>		29d. DATE SIGNED (Month, Day, Year) <i>November 14, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augustine P. Branguez MD, 3009 Reisterstown Rd. Pk. Sp. Md 20748</i>					
31. DATE FILED (Month, Day, Year) NOV 13 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36207

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES LEE ROWE				2. DATE OF DEATH MONTH NOVEMBER DAY 7 YEAR 1995		3. TIME OF DEATH 3:17 A	
4. SOCIAL SECURITY NUMBER 578-12-8558		5. SEX XX M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 27, 1918	
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY		9c. COUNTY OF DEATH PRINCE GEORGE'S	
10a. STATE N/A				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION WASHINGTON, DC	
10d. INSIDE CITY LIMITS? 1 YES 2 NO				10e. STREET AND NUMBER 308 34th STREET SE APT. #4			
10f. ZIP CODE 20019				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES XX NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WAREHOUSE MANAGER		16b. KIND OF BUSINESS/INDUSTRY PVT.			
17. FATHER'S NAME (First, Middle, Last) WILLIAM ROWE, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) MAYBELL BROWN			
19a. INFORMANT'S NAME (Type/Print) DEBORAH GREEN/ DAUGHTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7230 EAST FOREST RD. HYATTSVILLE, MD 20785			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK 11-11-95 LANDOVER, MD		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward Braxton</i>				22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Generalized Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Diabetes mellitus, non-insulin dependent DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):						Approximate interval Between Onset and Death years year	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypertension; Remote prior myocardial infarction						24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Berger MD</i>				29c. LICENSE NUMBER D25925		29d. DATE SIGNED (Month, Day, Year) November 10, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BERGER MD #205, 7720 WISCONSIN Ave, Bethesda, Md 20814							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


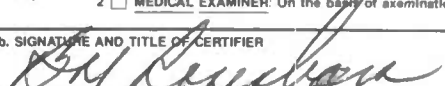
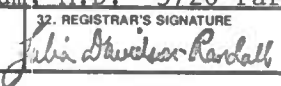
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21. 11. 1963

95 36208

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Herta Suchman				2. DATE OF DEATH MONTH DAY YEAR November 14, 1995		3. TIME OF DEATH 8:11 A M	
4. SOCIAL SECURITY NUMBER 082-14-8155		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 6, 1905	
8. BIRTHPLACE (State or Foreign Country) Austria				9. COUNTY OF DEATH Montgomery			
9a. FACILITY NAME (If not institution, give street and number) 410 Hillmoor Drive				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 410 Hillmoor Drive			
10f. ZIP CODE 20901				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner		16b. KIND OF BUSINESS/INDUSTRY Wholesale			
17. FATHER'S NAME (First, Middle, Last) Ferdinand Beck				18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Frankel			
19a. INFORMANT'S NAME (Type/Print) Susan Oseroff				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11607 Gilsan Street Silver Spring, Maryland 20902			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Moriah Cemetery 11/16/95		20c. LOCATION — City or Town, State Fairview, New Jersey			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 1 Day
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Alzheimer's Dementia							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D098344		29d. DATE SIGNED (Month, Day, Year) November 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Barry N. Rosenbaum, M.D. 3720 Farragut Avenue Kensington, Maryland 20895							
31. DATE FILED (Month, Day, Year) NOV 16 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36209

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Paul Francis Stamates				2. DATE OF DEATH MONTH DAY YEAR November 10, 1995		3. TIME OF DEATH 3:45 P M	
4. SOCIAL SECURITY NUMBER 212-54-2386		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 5, 1949	
8. BIRTHPLACE (State or Foreign Country) Washington, D.C.				9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park,	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Prince Georges	
10c. CITY, TOWN OR LOCATION Takoma Park				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 6823 Redtop Road	
10f. ZIP CODE 20912				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Shipping clerk		16b. KIND OF BUSINESS/INDUSTRY Retail Store/ Hecht Co	
17. FATHER'S NAME (First, Middle, Last) Paul Stamates				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Suckell			
19a. INFORMANT'S NAME (Type/Print) Eliel Pereira				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6823 Redtop Road Takoma Park, MD 20912			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) George Washington Cemetery Nov. 16, 1995		20c. LOCATION — City or Town, State Adelphi, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, D.C. 20012			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. intracerebral bleed / coma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. A-V malformation DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 2-3 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO N/A
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Rashid Baghai Naini				29c. LICENSE NUMBER D39372		29d. DATE SIGNED (Month, Day, Year) Nov 14 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RASHID BAGHAI-NAINI, M.D. 344 UNIV. BLVD. #324 SILVER SPRING, MD 20901							
31. DATE FILED (Month, Day, Year) NOV 16 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 36210

ITEMS: 10a-10f, PER INFORMANT FILM G-729 11/30/95 t.t

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Kate Stewart				2. DATE OF DEATH MONTH DAY YEAR November 8, 1995		3. TIME OF DEATH 948A M	
4. SOCIAL SECURITY NUMBER 021 26 3584		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 13, 1910	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
10a. STATE MA				10b. COUNTY SUFFOLK		10c. CITY, TOWN OR LOCATION Mitchellville BOSTON	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 11504 Chantilly La.				10f. ZIP CODE 20721 02115		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeper		16b. KIND OF BUSINESS/INDUSTRY Private Homes			
17. FATHER'S NAME (First, Middle, Last) Jefferson Stewart Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elnora Garlic			
19a. INFORMANT'S NAME (Type/Print) Jefferson Stewart Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11504 Chantilly La., Mitchellville, MD. 20721			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore Washington Crem. 11/13/95 Laurel, MD.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harvey E. Smith</i>				22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Wash., D.C. 20012			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Diagnosis: extensive atherosclerotic coronary cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER A21280		29d. DATE SIGNED (Month, Day, Year) November 9, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez MD, 3009 Rayburn Ct. Ct. Sp. MD 20748							
31. DATE FILED (Month, Day, Year) NOV 13 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 36211

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                   |  |                                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Clara Rolando Seater                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  | 2. DATE OF DEATH<br>MONTH 11 DAY 8 YEAR 95                                                                                                                                                                                                                                                   |  |                                                                                                                                                     |  | 3. TIME OF DEATH<br>6:39 A M                                                                                                                                                                        |  |                                                   |  |                                                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br>215-48-5936 A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                               |  | 6. AGE (In yrs. last birthday)<br>82 YRS.                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>May 31, 1913                                                                                                                                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Italy |  |                                                                                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Holy Cross Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |                                                                                                                                                                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Silver Spring                                                                                                |  |                                                                                                                                                                                                     |  | 9c. COUNTY OF DEATH<br>Montgomery                 |  |                                                                                                     |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                   |  |                                                                                                     |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  | 10b. COUNTY<br>Montgomery                                                                                                                                                                                                                                                                    |  |                                                                                                                                                     |  | 10c. CITY, TOWN OR LOCATION<br>Silver Spring                                                                                                                                                        |  |                                                   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>2325 Eastgate Drive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |                                                                                                                                                                                                                                                                                              |  | 10f. ZIP CODE<br>20906                                                                                                                              |  |                                                                                                                                                                                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA              |  |                                                                                                     |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                          |  |                                                                                                                                                     |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |                                                   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Secretary                                                                                                                                                                      |  |                                                                                                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Education                                                                                                                                                         |  |                                                   |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Ecillio Rolando                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |                                                                                                                                                                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Beatrice Pilati                                                                                |  |                                                                                                                                                                                                     |  |                                                   |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Stephen Seater                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |                                                                                                                                                                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2325 Eastgate Drive, Silver Spring, Maryland 20906 |  |                                                                                                                                                                                                     |  |                                                   |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                           |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Fort Lincoln Crematory 11/10                                                                                                                                                                              |  |                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br>Brentwood, Maryland                                                                                                                                          |  |                                                   |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Alan J. Donnell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |                                                                                                                                                                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br>Hines-Rinaldi Funeral Home<br>11800 New Hampshire Avenue<br>Silver Spring, Maryland 20904                       |  |                                                                                                                                                                                                     |  |                                                   |  |                                                                                                     |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute myocardial infarction<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. generalized atherosclerosis<br>c. d.<br>Approximate Interval Between Onset and Death Terminal |  |  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                   |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>prior CVA & hemiparesis                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                   |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                   |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                 |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                       |  | 28b. TIME OF INJURY<br>M                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                 |  |                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                       |  |                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                   |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                          |  |  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                   |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>George Sengstack, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |                                                                                                                                                                                                                                                                                              |  | 29c. LICENSE NUMBER<br>D12121                                                                                                                       |  |                                                                                                                                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br>11-8-95    |  |                                                                                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>George Sengstack, M.D. 3929 Ferrara Drive, Wheaton, Maryland 20906                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                   |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 13 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Anderson-Randall                                                                                                                                                                                                                                          |  |                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                   |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36212

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM THOMAS SIGLER</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 8, 1995</b>                                                                                                                                           |  | 3. TIME OF DEATH<br><b>10:00 P.M.</b>                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>234-38-8173</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                 |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>NOV. 23, 1925</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>                                                                                                                                              |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>                                                        |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>MONTGOMERY</b>                                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>BETHESDA</b>                                                                                                                                                      |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6101 BERKSHIRE DRIVE</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>20814</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>INVESTIGATOR</b>                                                                                                                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FEDERAL GOVERNMENT</b>                                                                                                                                         |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CURTIS MAXWELL SIGLER</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>KATHRYN MIDDLETON</b>                                                                                                                       |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ESTHER K. SIGLER</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6101 BERKSHIRE DR. BETHESDA, MD. 20814</b>                                                      |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>                                                                                                                                                                                              |  | DATE<br><b>11/11</b>                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State<br><b>SUITLAND, MARYLAND</b>                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Vernon J. Simmons</i>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOSEPH GAWLER'S SONS, INC.</b><br><b>5130 W. AVE. N.W. WASHINGTON, D.C. 20016</b>                                                                            |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| a. <i>Superior vena cava syndrome</i>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| b. <i>bronchogenic carcinoma</i>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| c. _____                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| d. _____                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Alan R. Pollock, MD</i>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D33443</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 9, 1995</b>                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Alan R. Pollock, MD 809 Viess Mill Rd Rockville, MD 20851</b>                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 13 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>                                                                                                                                           |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

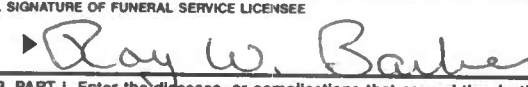
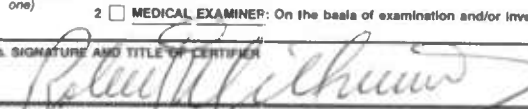
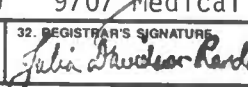
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36213

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>George R. Sexton                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 9, 1995                                                                                                                                              |  | 3. TIME OF DEATH<br>8:55A M                                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br>225-26-5966                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>74 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>March 4, 1921                                                |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Montgomery General Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Olney                                                                                                                                                        |  | 9c. COUNTY OF DEATH<br>Montgomery                                                                   |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br>Howard                                                                                                                                                                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br>Woodbine                                                                                                                                                             |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>Route 94, Box 3961                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21797                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                                      |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                             |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>unknown                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4<br>College (13-16) 0                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Carpenter                                                                                                                                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Construction                                                                                                                                                      |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>George W. Sexton                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Cynthia Self                                                                                                                                   |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Leonie Sexton                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Route 94, Box 3961, Woodbine, Maryland 21797                                                       |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rest Haven Memorial Park 11/13/95 Frederick, Maryland                                                                                                                                                                   |  | 20c. LOCATION — City or Town, State                                                                                                                                                                 |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>Muriel H. Barber Funeral Home 20882<br>P.O. Box 5038, Lavtonsville, Maryland                                                                                    |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pancreatic Carcinoma with hepatic metastases<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br>6 weeks |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diluted Cardiomyopathy, emphysema, coronary atherosclerosis<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                          |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                   |  |                                                                                                     |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>D13977                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 9, 1995                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Robert Millman, MD 9707 Medical Center Drive, #150, Rockville, Maryland 20850-3360                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 13 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                    |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

5+1

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36214

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Fay Taetle Snyder</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>NOV. 10 95</i>                                                                                                                                                                                                                                        |  | 3. TIME OF DEATH<br><i>1450</i> M                                                                                                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br><i>27-48-7766</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>75</i> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>12/15/19</i>                                                                                                                         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Shady Grove</i>                                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Rockville</i>                                                                                                                        |  |
| 9c. COUNTY OF DEATH<br><i>Montgomery</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 10a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><i>Montgomery</i>                                                                                                                                               |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Rockville</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><i>18 Monroe St., #205</i>                                                                                                                           |  |
| 10f. ZIP CODE<br><i>20850</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>                                                                                                                                                                                                                                          |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                                                                                                        |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>Homemaker</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>own home</i>                                                                                                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>David Taetle</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mary Smulian</i>                                                                                                                                                                                                                       |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Ben F. Snyder</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>118 Monroe St. Rockville, Md. 20850</i>                                                                                                                                                    |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Beth Shalom 11/12</i>                                                                                                                                                                                    |  | 20c. LOCATION — City or Town, State<br><i>Capitol Heights</i>                                                                                                                  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert Shalom</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Suspected Metastatic Breast Cancer</i><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST {<br>a. DUE TO (OR AS A CONSEQUENCE OF): <i>Ischemic Cardiomyopathy</i><br>b. DUE TO (OR AS A CONSEQUENCE OF): <i>Diabetes</i><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. Approximate Interval Between Onset and Death<br><i>2 months</i><br><i>5 years</i><br><i>20 years</i> |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic Renal Failure</i>                         |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                        |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                              |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Raymond Bass MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 29c. LICENSE NUMBER<br><i>D21340</i>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>Nov. 10, 1995</i>                                                                                                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>RAYMOND BASS 3941 Ferrara Wheaton Md 20906</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 13 1995</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John Director Randall</i>                                                                                                                                                                                                                                      |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

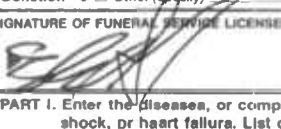
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36215

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Phyllis Rosena Schwartz                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov 9 1995                                                                                                                                                                                                                                                                                                                                                                                 |  | 3. TIME OF DEATH<br>5:45 P. M.                                                                                                                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br>123-18-9280                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>68 YRS.                                                                                                                                                                                                                                                                                                                                                                                        |  | 7. DATE OF BIRTH (Month, Day, Year)<br>March 10 1927                                                                                                                                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>New York                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br>5225 Pooks Hill Road                                                                                                                                                                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Bethesda                                                                                                                                        |  |
| 9c. COUNTY OF DEATH<br>Montgomery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 10a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br>Montgomery                                                                                                                                                              |  |
| 10c. CITY, TOWN OR LOCATION<br>Bethesda                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                  |  | 10e. STREET AND NUMBER<br>5225 Pooks Hill Road                                                                                                                                         |  |
| 10f. ZIP CODE<br>20814                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                                                                                                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                                                                                                                                                                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Aaron Sobel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ida Samuels                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Myron Schwartz                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5225 Pooks Hill Road Bethesda MD 20814                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>King David Memorial Gardens 11/12 Falls Church VA                                                                                                                                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br>Edward Sagel Funeral Direction<br>1091 Rockville Pike Rockville MD 20852                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. OVARIAN CARCINOMA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Joseph M. Haggerty MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 29c. LICENSE NUMBER<br>D32407                                                                                                                                                                                                                                                                                                                                                                                                    |  | 29d. DATE SIGNED (Month, Day, Year)<br>Nov. 10, 1995                                                                                                                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JOSEPH M. HAGGERTY MD 9711 MEDICAL CTR DR. ROCKVILLE MD. 20850                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 14 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson Randall                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36216

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charles W. Sickles</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 14, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>5:00 p. M</b>                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-32-4494</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>60</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Nov. 3, 1935</b>                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>                                                        |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>106 North Street</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>20850</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Korean</b>                                                                                                                                  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>8th</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Landscaper</b>                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Lawn Service</b>                                           |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Walter Sickles</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Scott</b>                                                                                                                         |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Francine S. McCants (Dau.)</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4011 Postgate Ter., #304, Silver Spring MD 20906</b>                                        |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parklawn Mem. Park 11/18 Rockville, MD</b>                                                                                                                                                               |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George R. Snowden</i>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>                                                                                                   |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>COMATOSE PATIENT</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>TERMINAL</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| b. <b>METASTATIC CARCINOMA</b> / STAGE <b>2 MONTHS</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>CARCINOMA</b> <b>2 years</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| c. <b>ORAL CARCINOMA</b> <b>2 months</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>POSSIBLE PULMONARY CARCINOMA</b> <b>2 months</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Adaoibi Stella Ideozor, M.D.</i>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D41987</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/95</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ADAOBI STELLA IDEOZOR, M.D. 444 NORTH FREDERICK AVE, #307 GAITHERSBURG, MD 20878</b>                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36217

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Nellie Estie Spurlin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH 11 DAY 14 YEAR 1995                                                                                                                                                                                                                                                                                                                                                                                    |  | 3. TIME OF DEATH<br>7:30 a.m.                                                                                                                                                          |  |
| 4. SOCIAL SECURITY NUMBER<br>218-32-6095                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>75 YRS.                                                                                                                                                                                                                                                                                                                                                                                        |  | 7. DATE OF BIRTH (Month, Day, Year)<br>05-18-20                                                                                                                                        |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>North Carolina                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br>3524 Clayton Road                                                                                                                                                                                                                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Joppa                                                                                                                                           |  |
| 9c. COUNTY OF DEATH<br>Harford                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br>Harford                                                                                                                                                                 |  |
| 10c. CITY, TOWN OR LOCATION<br>Joppa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br>3524 Clayton Road                                                                                                                                            |  |
| 10f. ZIP CODE<br>21085                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                                                                                                       |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Shoe Box Packer                                                                                                                                                                                                                                                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Shoe Manufacturing                                                                                                                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Dewey Lafayette Dancy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Nancy Verina Tucker                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Keith D. Spurlin, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>116 Ayers Drive, Rising Sun, Maryland 21911                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Bel Air Memorial Gardens 11/16/95                                                                                                                                                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br>Bel Air, Maryland                                                                                                                               |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John K. McComas</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br>Howard K. McComas III Funeral Home, P.A.<br>1317 Cokesbury Road, Abingdon, Md. 21009                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular Tachycardia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. Ischemic Cardiomyopathy<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Hypertension<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. Morbid obesity hyperlipidemia |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| Approximate Interval Between Onset and Death<br>minutes<br>years<br>years<br>years                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Gouty and Degenerative Joint Disease<br>Osteoporosis<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br>M                                                                                                                                                               |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Albert S. C. Sun, MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 29c. LICENSE NUMBER<br>D18779                                                                                                                                                                                                                                                                                                                                                                                                    |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 14, 1995                                                                                                                               |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Albert S. C. Sun MD 1800 Harford Road, Fallston, MD. 21047                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 15 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





95 36218

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Johanna</u> (NMN) <u>Samborsky</u>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <u>November</u> DAY <u>2</u> YEAR <u>1995</u>                                                                                                                         |  | 3. TIME OF DEATH<br><u>610 A</u> M                                                              |                                                                |
| 4. SOCIAL SECURITY NUMBER<br><u>130-09-3241</u>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><u>90</u> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>Sept. 20, 1905</u>                                    |                                                                |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Fallston General Hospital</u>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Fallston</u>                                                                                                                                          |  | 9c. COUNTY OF DEATH<br><u>Harford</u>                                                           |                                                                |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |
| 10a. STATE<br><u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><u>Montgomery</u>                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><u>Silver Spring</u>                                                                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                |
| 10e. STREET AND NUMBER<br><u>10813 Jewett Street</u>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><u>20902</u>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                     |                                                                |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>White</u>                         |                                                                |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+) <u>2</u>                                                                                                                                                                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Garment Maker</u>                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Manufacturing</u>                                                                                                                                          |  |                                                                                                 |                                                                |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Joseph Jaszczyszyn</u>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Unknown</u>                                                                                                                             |  |                                                                                                 |                                                                |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Ray Samborsky</u>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>309 Garnett Road, Joppa, MD 21085</u>                                                       |  |                                                                                                 |                                                                |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Mt. Olivet Cemetery</u>                                                                                                                                                                                  |  | 20c. DATE<br><u>11-8-95</u>                                                                                                                                                                     |  | 20d. LOCATION — City or Town, State<br><u>Maspeth, New York</u>                                 |                                                                |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Stephen A. Hughes</u>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><u>McComas Funeral Home</u><br><u>1317 Cokesbury Rd., Abingdon, MD 21009</u>                                                                                |  |                                                                                                 |                                                                |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  | a. <u>Progressive Respiratory Insufficiency</u>                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate interval Between Onset and Death<br><u>2 WEEKS</u> |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | b. <u>Chronic Obstructive Pulmonary Disease</u>                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | <u>1 YEAR</u>                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | c. _____                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | d. _____                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>DEMENTIA</u>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><u>M</u>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Linda Freilich</u>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><u>028335</u>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>November 2, 1995</u>                                  |                                                                |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Linda Freilich 101 E. Wheel Rd. Bel Air MD 21015</u>                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |
| 31. DATE FILED (Month, Day, Year)<br><u>NOV 13 1995</u>                                                                                                                                                                                                                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br><u>John Davidson-Hardall</u>                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36219

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WOODROW WILSON SEARS, SR</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 7, 1995</b>                                                                                                                                       |  | 3. TIME OF DEATH<br>M<br><b>10 25P</b>                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-16-1770</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 9, 1923</b>                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Prince George's Hospital Center</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cheverly</b>                                                                                                                                              |  | 9c. COUNTY OF DEATH<br><b>Prince George's</b>                                                       |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>Prince George's</b>                                                                                                                                                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br><b>Lanham</b>                                                                                                                                                        |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6000 Shephard Lane</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>20706</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                      |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>7</b>                                                                                                                                                                                                                                                                                                                    |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Refrigeration Mechanic</b>                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>District of Columbia Government</b>                                                                                                                            |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Grover C. Sears</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Eugia Ellen Jones</b>                                                                                                                       |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Gloria Farrell</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. #1, Box 740, Sanderson, Florida 32087</b>                                                   |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery 11/11/95</b>                                                                                                                                                                                   |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Maryland</b>                                                                                                                                   |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>H. Constance Gasch</i>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Francis Gasch's Sons Funeral Home, P.A.<br/>4739 Baltimore Ave., Hyattsville, MD 20781</b>                                                                   |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Squamous Cell Cancer of the lung</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| b. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| c. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| d. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Overlaid disease of the colon</b><br><b>Sepsis</b>                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY M                                                                                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Lois J. Lewis</i>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D14350</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/8/95</b>                                               |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kai-Yin Yeh, 8826 Woodward Road #201, Clarksburg, MD 20734</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 13 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36220

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Alvin Lewis Smith</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 8, 1995</b>                                                                                                                                           |  | 3. TIME OF DEATH<br><b>4:50 P. M</b>                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-70-0628</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>44</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 8, 1951</b>                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>                                                                                                                                              |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                          |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>10308 Julep Avenue</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>20702</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                        |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bus Operator</b>                                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Government</b>                                                                                                                                                 |  |                                                                                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harry Lewis Smith</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Waldon</b>                                                                                                                        |  |                                                                                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Erica D. Smith</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3748 1st Street, S. E., #4, Washington, D. C.</b>                                               |  |                                                                                                   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery 11/14/95</b>                                                                                                                                                                                   |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, MD</b>                                                                                                                                         |  |                                                                                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John T. Stewart III</i>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STEWART FUNERAL HOME<br/>4001 Benning Road, N.E., Washington, D.C.</b>                                                                                       |  |                                                                                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| b. <b>Coronary Artery Disease</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| c. <b>Atherosclerotic heart disease</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| d. <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO              |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Pankaj Lal MD</i>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D39671</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 9, 1995</b>                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Pankaj Lal, 11120 New Hampshire Avenue, Silver Spring, MD 20904 #100</b>                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 15 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>                                                                                                                                                     |  |                                                                                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text at the bottom of the page, possibly a signature or date.

95 36221

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>YUNG-King TIONG</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 14 1995</b>                                                                                                                                   |  | 3. TIME OF DEATH<br><b>4:29 p.m.</b>                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                       |  | 8. AGE (In yrs. last birthday)<br><b>53</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>October 15, 1942</b>                               |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Suburban Hospital</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>                                                                                                                                          |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                        |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>Sarainak</b>                                                                                                                                                                                                                                                   |  | 10c. CITY, TOWN OR LOCATION<br><b>Miri</b>                                                                                                                                                      |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>7 Piasau Park</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                  |  | 10f. ZIP CODE<br><b>98008</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>Malaysia</b>                                                |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                     |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Malaysian Chinese</b>             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                               |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Timber Businessman</b>                                                                                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Timber</b>                                                                                                                                                 |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Toh Siong Tiong</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Noon Kiew Wong</b>                                                                                                                      |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>I K King Tiong</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11 Collyer Quay #15-01 Singapore 0104</b>                                                   |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Miri Cemetery November 22, 1995</b>                                                                                                                                                        |  | 20c. LOCATION — City or Town, State<br><b>Miri, Sarawak</b>                                                                                                                                     |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert A. Pumphrey</b>                                                                                                                                                                                                                                                                                                                                                       |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/<br/>Bethesda-Chevy Chase, Inc. 7557 Wisconsin<br/>Avenue Bethesda, Maryland 20814-3501</b>                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary edema</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Sequitely illat conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>Coronary artery disease</b>                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Pankaj Lal M.D.</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>D39671</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 14, 1995</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Pankaj Lal M.D. 11119 Rockville Pike #100 Rockville, Maryland 20852</b>                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br><b>Juba Shuleson-Radell</b>                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

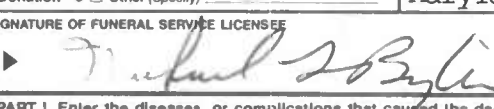
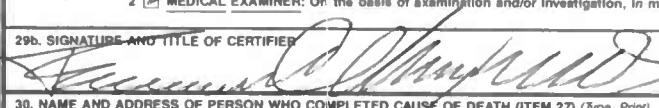
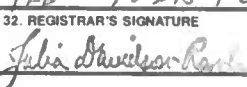




95 36222

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES LEE THORPE</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>14</b> YEAR <b>95</b>                                                                                                                                                                                                                              |  | 3. TIME OF DEATH<br><b>6:13 AM</b>                                                                                                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-42-9941</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>50</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>October 6, 1945</b>                                                                                                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Suburban Hospital</b>                                                                                                                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>                                                                                                                         |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                               |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>9902 Capital View Avenue</b>                                                                                                                      |  |
| 10f. ZIP CODE<br><b>20910</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                 |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                        |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary 12</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>cab driver</b>                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Taxi</b>                                                                                                                                  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Archie HODGES</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Blanche THORPE</b>                                                                                                                                                                                                                     |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lucinda Thorpe</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9902 Capital View Ave., Silver Spring, MD. 20910</b>                                                                                                                                       |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Maryland Veterans Cemetery Nov. 17, 1995 Cheltenham, MD.</b>                                                                                                                                             |  | 20c. LOCATION — City or Town, State                                                                                                                                            |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Takoma Funeral Home<br/>254 Carroll St. NW, Washington, D.C. 20012</b>                                                                                                                                                                                  |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDIAL INFARCTION</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>007099</b>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 14 95</b>                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FRANCIS C MAYLE 1025 FORDWOOD RD BETHESDA MD 20817</b>                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 16 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                               |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36223

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HAY BROOKE TALIAFERRO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>7</b> YEAR <b>1995</b>                                                                                                                         |  | 3. TIME OF DEATH<br><b>9 59 AM</b>                                                              |                                                                                                                                                    |
| 4. SOCIAL SECURITY NUMBER<br><b>217-28-7869</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 19, 1906</b>                                     |                                                                                                                                                    |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>                                                                                                                                     |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                        |                                                                                                                                                    |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>                                                                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                                    |
| 10e. STREET AND NUMBER<br><b>321 University Boulevard West</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>20901</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                                                                    |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |                                                                                                                                                    |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machinist</b>                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>United States Navy Department</b>                                                                                                                          |  |                                                                                                 |                                                                                                                                                    |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Taliaferro</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Florence Columbus</b>                                                                                                                   |  |                                                                                                 |                                                                                                                                                    |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ruth Taliaferro</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>321 University Boulevard West, Silver Spring, MD 20901</b>                                  |  |                                                                                                 |                                                                                                                                                    |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery 11/10/95</b>                                                                                                                                                                        |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, MD</b>                                                                                                                                     |  |                                                                                                 |                                                                                                                                                    |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott L. Smith</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd. W. Sil. Spr. MD 20901</b>                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CONGESTIVE HEART FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. ATRIAL FIBRILLATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. DIABETES MELLITUS</b><br>Approximate Interval Between Onset and Death<br><b>15 YEARS</b><br><b>15 YEARS</b><br><b>20 YEARS</b><br><b>UNCERTAIN</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                                                                    |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 29. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |  |                                                                                                 |                                                                                                                                                    |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                             |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Charles M Benner MD</i>                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>DS1563</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 7, 1995</b>                                  |                                                                                                                                                    |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHARLES M BENNER MD, 11251 LOCKWOOD DRIVE, SILVER SPRING, MD 20901</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 13 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SETH MICHAEL TROTTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |                                                  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 07, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>2212 P M</b>                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-02-7174</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br><b>23</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 10, 1972</b>                                                                                                                                     |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                 |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>                                                                                                                                          |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>                                                    |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                                  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>                                             |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |                                                  | 10e. STREET AND NUMBER<br><b>14416 Parkvale Road, #5</b>                                                                                                                                        |  |                                                                                             |  |
| 10f. ZIP CODE<br><b>20853</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                                  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                           |  |                                                                                             |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b><br>College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Financial Analyst</b>                                                                                                                                                         |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Business Machines</b>                                                                                                                                      |  |                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Arthur Trotter, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Michele Kay Castell</b>                                                                                                                 |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Michele Kay Trotter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14416 Parkvale Road, #5, Rockville, Maryland 20853</b>                                      |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b><br><b>November 13, 1995</b>                                                                                                                                                  |                                                  | 20c. LOCATION — City or Town, State<br><b>Silver Spring, Maryland</b>                                                                                                                           |  |                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Barbara J. McMullen Lawrence</i><br><b>M00831</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/<br/>Rockville, Inc. 300 West Montgomery<br/>Avenue, Rockville, Maryland 20850-2805</b>                                                                                                                                 |                                                  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE INJURIES</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11/7/95</b>                                                                                                                                                                                                                                       |                                                  | 28b. TIME OF INJURY<br><b>0935A</b>                                                                                                                                                             |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>OCCUPANT OF AUTO VS AUTO COLLISION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)<br><b>STREET</b>                                                                                                                                                                                        |                                                  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>NORBELIC &amp; BALTIMORE RD, ROCKVILLE MD</b>                                                                |  |                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i><br><b>MARIO F. GOLUB JR MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |                                                  | 29c. LICENSE NUMBER<br><b>O.C.M.E</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 8, 1995</b>                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARIO F. GOLUB JR MD 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 14 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

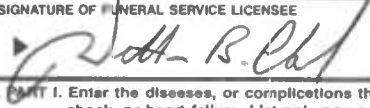
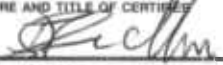
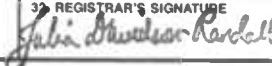
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36225

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SIDNEY TREITEL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                                  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>16,</b> YEAR <b>1995</b>                                                                                                                           |  | 3. TIME OF DEATH<br><b>5:45 A M</b>                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>110-07-9960</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 27, 1910</b>                                                                                                                                    |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Fairfield Nursing Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Crownsville</b>                                                                                                                                       |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>                                                      |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                                                                                                                               |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>10500 Rockville Pike #804</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                                  | 10f. ZIP CODE<br><b>20853</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                           |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Coast Guard WW II</b>                                                                                                                       |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Owner / Operator</b>                                                                                                                                                          |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Retail Liquor Store</b>                                                                                                                                    |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Henry Treitel</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Dora Stern</b>                                                                                                                          |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Edna S. Treitel (Wife)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as #10</b>                                                                             |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>                                                                                                                                                                                 |                                                  | 20c. LOCATION — City or Town, State<br><b>11-17 Beltsville, MD</b>                                                                                                                              |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><br><b>MO0827</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rapp Funeral Services, P.A.<br/>933 Gist Ave, Silver Spring, MD 20910</b>                                                                                                                                                                               |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Aspiration</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d.</b> |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia, Dysphagia, Decubitus ulcers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                                  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                  | 29c. LICENSE NUMBER<br><b>D38958</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov. 16, 1995</b>                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Daljeet Singh Sidhu, M.D. 1413 Annapolis Rd #106 Odenton, MD 21113</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |                                                  | 32. REGISTRAR'S SIGNATURE<br>                                                                                |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Released by John F. Tauber, M. D., Deputy Medical Examiner 11-17-95

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36226

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LANH TRANG</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 12, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>7:45 PM</b>                                                                                                                                                                                                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>189-60-0844</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 1, 1923</b>                                                                                                                                                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                                                                                                                                                                                                               |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>Germantown</b>                                                                                                                                                                                                                                       |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | 10e. STREET AND NUMBER<br><b>16 Drumcastle Court</b>                                                                                                                                                |  |                                                                                                                                                                                                                                                                                        |  |
| 10f. ZIP CODE<br><b>20876</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>Vietnam</b>                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                        |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                         |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Vietnamese</b>                                                                                                                                                                                                        |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ba V. Ngo</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bay Ngo</b>                                                                                                                                 |  |                                                                                                                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Kim Trang</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16 Drumcastle Court, Germantown, Maryland 20876</b>                                             |  |                                                                                                                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                 |  | 20c. LOCATION — City or Town, State<br><b>11/15 Alexandria, Virginia</b>                                                                                                                            |  | 20d. DATE<br><b>11/15</b>                                                                                                                                                                                                                                                              |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael D. Cebbens</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DeVol Funeral Home</b><br><b>10 E. Deer Park Dr., Gaithersburg, MD. 20877</b>                                                                                |  |                                                                                                                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pneumonia</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><b>3 day</b> |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                              |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                     |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |
| 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                      |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                                                                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                               |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Raymond Bass</i> MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>D 21340</b>                                                                                                                                                               |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 13, 1995</b>                                                                                                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RAYMOND BASS 3941 Ferrara Dr. Wheaton Md 20906</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Randall</i>                                                                                                                                             |  |                                                                                                                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36227

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                                                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Hilda LaRue Tipton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH <b>Nov.</b> DAY <b>18,</b> YEAR <b>1995</b>                                                                                                                           |  | 3. TIME OF DEATH<br><b>6 a.m.</b>                                                                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-01-0464</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct. 27, 1918</b>                                                                              |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>1831 Old Westminster Pike</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Finksburg</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>                                                                                                    |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                     |  | 10b. COUNTY<br><b>Carroll</b>                                                                                                                                                                   |  | 10c. CITY, TOWN OR LOCATION<br><b>Finksburg</b>                                                                                          |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                     |  | 10e. STREET AND NUMBER<br><b>1831 Old Westminster Pike</b>                                                                                                                                      |  |                                                                                                                                          |  |
| 10f. ZIP CODE<br><b>21048</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                           |  |                                                                                                                                          |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>                                                                                                                                                      |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Public Schools</b>                                                                                                                                         |  |                                                                                                                                          |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Albert R. Shubkagle</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bertha L. Frieese</b>                                                                                                                   |  |                                                                                                                                          |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Thomas Turner Tipton III</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1102 Bollinger Road, Westminster, MD 21157</b>                                              |  |                                                                                                                                          |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Evergreen Memorial Gardens</b>                                                                                                                                                                |  | 20c. LOCATION — City or Town, State<br><b>Finksburg, MD</b>                                                                                                                                     |  |                                                                                                                                          |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Mark A. [Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Price's Funeral Home &amp; Chapel<br/>412 Washington Rd., Westminster, MD 21157</b>                                                                      |  |                                                                                                                                          |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute Myocardial Infarction</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>C.A.D.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  | Approximate Interval Between Onset and Death<br><b>Before death 1993</b>                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>High Blood Pressure w/ Bleeding Aneurysm</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                    |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                          |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                                                          |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                          |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br><b>018097</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-20-95</b>                                                                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Thomas Turner Tipton III 10645 59th Westminster Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                                                          |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 20 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><b>J. [Signature]</b>                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                                                          |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

52

95 36228

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GLADYS G TAYLOR</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>23</b> YEAR <b>95</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>7:23 PM</b>                                                          |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-46-3565</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>DEC. 3, 1903</b>                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>FAUSTON GENERAL HOSPITAL</b>                                                                                               |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FALLSTON</b>                                      |  |
| 9c. COUNTY OF DEATH<br><b>HARFORD</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 10a. STATE<br><b>MD</b>                                                                                                                                                                         |  | 10b. COUNTY<br><b>HARFORD</b>                                                               |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BEL AIR</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>BEL FOREST NURSING CENTER</b>                                  |  |
| 10f. ZIP CODE<br><b>21014</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                     |  |                                                                                             |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>8TH</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>BEAUTICIAN</b>                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>PERSONAL CARE</b>                                                                                                                                          |  |                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HENRIETTA WILSON</b>                                                                                                                    |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>HELEN SCOTT</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1537 SHEFFIELD RD. BALTIMORE, MD 21218</b>                                                  |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, chapel or other place)<br><b>BERRY CEMETERY</b>                                                                                                                                                                                       |  | 20c. DATE<br><b>10/23/95</b>                                                                                                                                                                    |  | 20d. LOCATION — City or Town, State<br><b>DARLINGTON, MD</b>                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BEARD FUNERAL HOME 21018<br/>552 LEWIS ST. HAORE DE GRACE, MD</b>                                                                                        |  |                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. asphyxiation pneumonia</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>diabetes mellitus</b><br><b>breast cancer</b>                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |                                                                                             |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>D32295</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/24/95</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DAVID S. DUNN 1131 Belair Rd</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 13 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                   |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36229

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KELSEY EIKO THOMPSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 1 1995</b>                                                                                                                                        |  | 3. TIME OF DEATH<br><b>3:32 P M</b>                                                                 |                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br><b>No Number</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br><b>6 6</b>                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>November 1, 1995</b>                                      |                                                                                                                                             |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                 |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>                                                                                                                                              |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>                                                            |                                                                                                                                             |
| 9b. FACILITY NAME (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                 |  | 10. RESIDENCE OF DECEDENT                                                                                                                                                                           |  |                                                                                                     |                                                                                                                                             |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>United States Armed Forces</b>                                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>BETHESDA</b>                                                                                                                                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                             |
| 10e. STREET AND NUMBER<br><b>PSC-1003, Box 16 FPOAE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                 |  | 10f. ZIP CODE<br><b>09728</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States of America</b>                                    |                                                                                                                                             |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |                                                                                                                                             |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>-0-</b> College (1-4 or 5+) <b>Never Employed</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Never Employed</b>                                                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>                                                                                                                                                       |  |                                                                                                     |                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Orlando S. Thompson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Deborah E. Geyer</b>                                                                                                                        |  |                                                                                                     |                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Orlando S. Thompson (Father)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>NOT AVAILABLE</b>                                                                               |  |                                                                                                     |                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Long's Cemetery 11/9 1995</b>                                                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br><b>Halifax, Pennsylvania</b>                                                                                                                                 |  |                                                                                                     |                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Howard Carson #M00690</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hooover Funeral Homes 118 South Market Street, Millersburg, PA</b>                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEVERE PULMONARY INSUFFICIENCY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>PREMATURITY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death                                                                                                |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                 |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                                                     |                                                                                                                                             |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                               |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>W. Adelman M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                 |  | 29c. LICENSE NUMBER<br><b>RES-000</b>                                                                                                                                                               |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov, 02, 95</b>                                           |                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>W. ADELMAN, CAPT, MC, USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                 |  | 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                             |  |                                                                                                     |                                                                                                                                             |
| 32. REGISTRAR'S SIGNATURE<br><b>John D. ...</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ESS 17 2

NOV 7 1932  
J. J. J. J. J.



95 36230

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                                      |                                                                                                     |                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Joaquim Cota Viegas                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 14 1995                                                                                                                                              |                                                      | 3. TIME OF DEATH<br>8:09 A M                                                                        |                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br>217-84-2301                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             | 6. AGE (In yrs. last birthday)<br>64 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>October 22, 1931                                                                                                                                          | 8. BIRTHPLACE (State or Foreign Country)<br>Tanzania |                                                                                                     |                                                                                                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Anne Arundel Medical Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Annapolis                                                                                                                                                    |                                                      | 9c. COUNTY OF DEATH<br>Anne Arundel                                                                 |                                                                                                                                             |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                                      |                                                                                                     |                                                                                                                                             |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. COUNTY<br>Anne Arundel                                                                                                                                                                                                                                                                                |                                           | 10c. CITY, TOWN OR LOCATION<br>Annapolis                                                                                                                                                            |                                                      | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                             |
| 10e. STREET AND NUMBER<br>1011 Smithville Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |                                           | 10f. ZIP CODE<br>21401                                                                                                                                                                              |                                                      | 10g. CITIZEN OF WHAT COUNTRY?<br>Tanzania                                                           |                                                                                                                                             |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                                      | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |                                                                                                                                             |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Maintenance Man                                                                                                                                                                           |                                           | 16b. KIND OF BUSINESS/INDUSTRY<br>Restaurant                                                                                                                                                        |                                                      |                                                                                                     |                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br>Roque Caetano Viegas                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Maria Cecilia Cota                                                                                                                             |                                                      |                                                                                                     |                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mary J. Viegas                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1011 Smithville Street, Annapolis, MD 21401                                                        |                                                      |                                                                                                     |                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery 11/17/95                                                                                                                                                                                        |                                           | 20c. LOCATION — City or Town, State<br>Silver Spring, MD                                                                                                                                            |                                                      |                                                                                                     |                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James S. Dady</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |                                           | 22. NAME AND ADDRESS OF FACILITY<br>Francis J. Collins Funeral Home, Inc.<br>500 University Blvd. W. Sil. Spr. MD 20901                                                                             |                                                      |                                                                                                     |                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Cardiac Arrest<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Ischemic Cardiomyopathy<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Coronary Artery Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. Diabetes<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                                      |                                                                                                     | Approximate Interval Between Onset and Death<br>20 Min.<br>5 Yrs.<br>Yrs.<br>4 Yrs.                                                         |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Laryngeal Carcinoma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                                      |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                                      |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                     |                                                      |                                                                                                     |                                                                                                                                             |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                  |                                           | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |                                                      | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |                                           | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |                                                      | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                                      |                                                                                                     |                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James W. Ruppel MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |                                           | 29c. LICENSE NUMBER<br>D25499                                                                                                                                                                       |                                                      | 29d. DATE SIGNED (Month, Day, Year)<br>11/16/95                                                     |                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>James W. Ruppel MD 180 Admiral Cochrane Dr Annapolis MD 21401                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                                      |                                                                                                     |                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br>NOV 17 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |                                           | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Carroll</i>                                                                                                                                             |                                                      |                                                                                                     |                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36231

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Rodney George Valencia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 10, 1995                                                                                                                                         |  |                                                                                             |  | 3. TIME OF DEATH<br>12:10 P M                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br>579-44-5034                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br>59 YRS.                                                                                                                                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                              |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                                                                          |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Nov. 21, 1935                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 8. BIRTHPLACE (State or Foreign Country)<br>Washington, D.C.                                                                                                                                    |  |                                                                                             |  |                                                                                                                                         |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>HOLY CROSS HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>SILVER SPRING                                                                                                                                            |  |                                                                                             |  | 9c. COUNTY OF DEATH<br>MONTGOMERY                                                                                                       |  |
| 10a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. COUNTY                                                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br>Washington, D.C.                                                                                                                                                 |  |                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br>1548 Northgate Road, N.W.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br>20012                                                                                                                                                                          |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                              |  |                                                                                                                                         |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                         |  |                                                                                                                                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Computer Specialist                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Federal Government                                                                                                                                            |  |                                                                                             |  |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Andrew Valencia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>LaVerne Lacey                                                                                                                              |  |                                                                                             |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Rodney G. Valencia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1548 Northgate Road, N.W., Washington, D.C. 20012                                              |  |                                                                                             |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                       |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Olivet Cemetery                                                                                                                                                                                         |  | DATE<br>11/15                                                                                                                                                                                   |  | 20c. LOCATION — City or Town, State<br>Washington, D.C.                                     |  |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Henry B. Robbins</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br>McGuire Funeral Service, Inc. 20012<br>7400 Georgia Ave. N.W., Washington, D.C.                                                                             |  |                                                                                             |  |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Congestive Heart Failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Ischemic Heart Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  | Approximate interval Between Onset and Death<br>12 hrs<br>10 yrs                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic Renal Insufficiency</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                       |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |  |                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Stephen Hellman</i>                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br>D20624                                                                                                                                                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/11/95                                             |  |                                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Stephen Hellman 6240 Montrose Rd. Rockville Md 20854                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 15 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Randall</i>                                                                                                                                         |  |                                                                                             |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36232

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                               |  |                                                                                             |  |                                                                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Marcella Nancy Vandevander</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 15, 1995</b>                                                                                                                                |  |                                                                                             |  | 3. TIME OF DEATH<br><b>8:28 AM</b>                                                                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-34-8375</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                       |  | 6. AGE (In yrs. last birthday)<br><b>58</b> YRS.                                                                                                                                              |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>March 25, 1937</b>                             |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>                                                                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Fallston General Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Fallston</b>                                                                                                                                        |  |                                                                                             |  | 9c. COUNTY OF DEATH<br><b>Harford</b>                                                                                                              |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. COUNTY<br><b>Harford</b>                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>Joppa</b>                                                                                                                                                   |  |                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><b>1003 Pine Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                  |  | 10f. ZIP CODE<br><b>21085</b>                                                                                                                                                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                 |  |                                                                                                                                                    |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                     |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                     |  |                                                                                                                                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>8</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>                                               |  |                                                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Martin Blackburn</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Edna Fanny Martin</b>                                                                                                                 |  |                                                                                             |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rita G. Sledzik</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rd. 2, Box 2033, Spring Grove, Pennsylvania 17362</b>                                     |  |                                                                                             |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holly Hill Memorial Park 11/18/95 Baltimore, Maryland</b>                                                                                                                                  |  |                                                                                                                                                                                               |  | 20c. LOCATION — City or Town, State                                                         |  |                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Stephen A. Hughes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Md. 21009</b>                                                              |  |                                                                                             |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Atherosclerotic Coronary Vascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                               |  |                                                                                             |  | Approximate Interval Between Onset and Death<br><b>hours</b>                                                                                       |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SIP SAN with (L) hemiparesis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                               |  |                                                                                             |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                               |  |                                                                                             |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                               |  |                                                                                             |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                        |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                      |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |  |                                                                                             |  |                                                                                                                                                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                    |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kevin L. Snyder MD</b>                                                                                                                                                                                                               |  |                                                                                                                                                                                               |  | 29c. LICENSE NUMBER<br><b>D33642</b>                                                        |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 16, 1995</b>                                                                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KEVIN L. Snyder 754 Hickory Ave. Bel Air, Md. 21014</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                               |  |                                                                                             |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                                                                                                                                                                                                       |  |                                                                                                                                                                                               |  |                                                                                             |  |                                                                                                                                                    |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

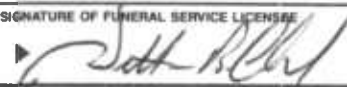

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36233

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CORY TREVOR WHARTON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>9</b> YEAR <b>95</b>                                                                                                                                 |  | 3. TIME OF DEATH<br><b>05:30 A M</b>                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (in yrs. last birthday)<br>YRS. MONTHS DAYS <b>3 0</b>                                                                                                                                   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11-9-95</b>                                          |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>                                                                                                     |  |                                                                                                |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 11. COUNTY OF DEATH<br><b>Montgomery</b>                                                                                                                                                        |  |                                                                                                |  |
| 12. STATE<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 13. COUNTY<br><b>None</b>                                                                                                                                                                                                                                                                   |  | 14. CITY, TOWN OR LOCATION<br><b>Washington, D.C.</b>                                                                                                                                           |  | 15. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 16. STREET AND NUMBER<br><b>1124 - 44th Place, SE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 17. ZIP CODE<br><b>20019</b>                                                                                                                                                                    |  | 18. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                           |  |
| 19. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                             |  | 21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 22. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                     |  |
| 23. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>N/A</b>                                                                                                                                                                     |  | 25. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>                                                                                                                                                     |  |                                                                                                |  |
| 26. FATHER'S NAME (First, Middle, Last)<br><b>Cory T. Wharton, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 27. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Darlene Lawan Brent</b>                                                                                                                 |  |                                                                                                |  |
| 28. INFORMANT'S NAME (Type/Print)<br><b>Darlene W. Brent (Mother)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as #10</b>                                                                              |  |                                                                                                |  |
| 30. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                    |  | 31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>                                                                                                                                                                               |  | 32. DATE<br><b>11-15</b>                                                                                                                                                                        |  | 33. LOCATION — City or Town, State<br><b>Beltsville, MD</b>                                    |  |
| 34. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><br><b>M00827</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 35. NAME AND ADDRESS OF FACILITY<br><b>Rapp Funeral Services, P.A.<br/>933 Gist Ave, Silver Spring, MD 20910</b>                                                                                                                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                |  |
| 36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. respiratory failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>b. extreme prematurity</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>3 hrs</b><br><b>3 hrs</b> |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                |  |
| 37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                |  |
| 38. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 39. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                |  |
| 40. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                 |  | 41. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                       |  | 42. TIME OF INJURY<br><b>M</b>                                                                                                                                                                  |  | 43. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 44. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 45. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                |  |                                                                                                |  |
| 46. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                             |  | 47. SIGNATURE AND TITLE OF CERTIFIER<br><b>Joan M. Kelly, M.D.</b>                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                |  |
| 48. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOAN M. KELLY, M.D. 1500 FOREST GLEN RD. SILVER SPRING, MD 20910</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 49. LICENSE NUMBER<br><b>D38744</b>                                                                                                                                                                                                                                                         |  | 50. DATE SIGNED (Month, Day, Year)<br><b>11/9/95</b>                                                                                                                                            |  |                                                                                                |  |
| 51. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 52. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36234

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                            |  |                                                                              |  |                                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lillian J. Walker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 7, 1995</b>                                                                                                                                                                                                                  |  |                                                                              |  | 3. TIME OF DEATH<br><b>7:50 p. M</b>                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-42-7972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.                                                                                                                                                                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                               |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                                        |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Mar. 12, 1910</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                |  |                                                                              |  |                                                                                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Montgomery General Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Olney</b>                                                                                                                                                                                                                        |  |                                                                              |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>                                                              |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Olney</b>                                  |  |                                                                                                       |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>17532 Georgia Ave., P.O. Box 74</b>                                                                                                                                                                                                           |  | 10f. ZIP CODE<br><b>20832</b>                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                        |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                            |  |                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                                                                                                                                          |  |                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Carter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Chase</b>                                                                                                                                                                                                    |  |                                                                              |  |                                                                                                       |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Clarence A. Walker (Husband)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17532 Georgia Ave., Box 74, Olney, MD 20832</b>                                                                                                                        |  |                                                                              |  |                                                                                                       |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Zion Church Cem. 11/15 Olney, MD</b>                                                                                                                                             |  |                                                                              |  | 20c. LOCATION — City or Town, State                                                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George K. Mauldin</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>                                                                                                                                                                              |  |                                                                              |  |                                                                                                       |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                            |  |                                                                              |  | Approximate Interval Between Onset and Death<br><b>10 days</b>                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Acute + chronic renal failure</b><br><b>Diabetes mellitus</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                            |  |                                                                              |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                            |  |                                                                                                                                                                                                                                                                            |  |                                                                              |  |                                                                                                       |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)                                       |  | 28b. TIME OF INJURY<br><b>M</b>                                                                       |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                            |  |                                                                                                                                                                                                                                                                            |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |                                                                                                       |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                         |  |                                                                                                                                              |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dennis M. Hannan</i>                                                                                                                                                                                                           |  |                                                                              |  | 29c. LICENSE NUMBER<br><b>D23124</b>                                                                  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 8-95</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DENNIS HANNAN, MD 3416 OLANDWOOD COURT OLNEY, MD 20832</b>                                                                                                                       |  |                                                                              |  |                                                                                                       |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 13 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>                                                                                                                                                                                                                  |  |                                                                              |  |                                                                                                       |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36235

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Bernard William Woodward</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 11, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>11:45 P M</b>                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>476-05-4180</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 26, 1907</b>                                         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Kentucky</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Kensington Gardens Nursing Home</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Kensington</b>                                                                                                                                            |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                            |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Bethesda</b>                                                                                                                                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>8800 Ridge Road</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>20817</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                               |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Patent Searcher</b>                                                                                                                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Law</b>                                                                                                                                                        |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Franklin Woodward</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mattie Helen Lovelace</b>                                                                                                                   |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nora W. Cott</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8800 Ridge Road, Bethesda, Maryland 20817</b>                                                   |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>November 13, 1995</b><br><b>Montgomery Crematorium, Inc.</b>                                                                                                                                                         |  | 20c. LOCATION — City or Town, State<br><b>Bethesda, Maryland</b>                                                                                                                                    |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael E. Higgins</i>                                                                                                                                                                                                                                                                                                                                                           |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey</b><br><b>Chevy Chase, Inc.</b><br><b>Bethesda, Maryland</b>                                                                                                                                                                                     |  | 23. ADDRESS OF FACILITY<br><b>Funeral Home/Bethesda-<br/>7557 Wisconsin Avenue<br/>20814-3501</b>                                                                                                   |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Myocardial Infarction</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Arteriosclerotic Heart Disease</b>                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimers Disease</b>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |  |                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John F. Gustafson, M.D.</i>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D15049</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 13, 1995</b>                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John Gustafson, M.D., 5480 Wisconsin Avenue, Chevy Chase, Maryland 20815-3530</b>                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 14 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br><i>John Gustafson-Randall</i>                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

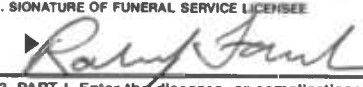

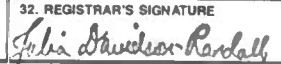
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36236

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PATRICK B. WIDMARK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>4,</b> YEAR <b>1995</b>                                                                                                                            |  | 3. TIME OF DEATH<br><b>1:00 P M</b>                                                             |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>079-46-7233</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>27</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>APR. 10, 1968</b>                                     |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>NEW York</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>                                                                                                                                          |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>                                                        |                                                                                                       |
| 9b. FACILITY NAME (If not institution, give street and number)<br><b>7409 CRESTBERRY LA.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | RESIDENCE OF DECEDENT                                                                                                                                                                           |  |                                                                                                 |                                                                                                       |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Bethesda</b>                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>7409 Crestberry Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>20817</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                           |                                                                                                       |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |                                                                                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>None</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>None</b>                                                                                                                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>                                                                                                                                                   |  |                                                                                                 |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Rudolph M. Widmark</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sandra Barbuta</b>                                                                                                                      |  |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rudolph M. Widmark, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7409 Crestberry Lane, Bethesda, Maryland 20817</b>                                          |  |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc. NOV. 7, 1995</b>                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br><b>Bethesda, Maryland</b>                                                                                                                                |  |                                                                                                 |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br> <b>M00198</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/<br/>Bethesda-Chevy Chase, Inc.<br/>7557 Wisconsin Ave., Bethesda, MD 20814-3501</b>                                     |  |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CANCER OF THE BRAIN</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>26 YRS.</b>                                        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                       |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                 |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>001019</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/4/95</b>                                           |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FRED A. GILL M.D. 10816 FOX HUNT LA., POTOMAC, MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 14 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36237

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                 |  |                                                                                                                   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Charles Washington                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 16, 1995                                                                                                                                         |  | 3. TIME OF DEATH<br>7:32 A M                                                                                      |  |
| 4. SOCIAL SECURITY NUMBER<br>218-34-6463                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 6. AGE (In yrs. last birthday)<br>54 YRS.                                                                                                                                                       |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>SEPT. 27, 1941                                                          |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Physicians Memorial Hospital                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>La Plata                                                                   |  |
| 9c. COUNTY OF DEATH<br>Charles                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10a. STATE<br>MARYLAND                                                                                                                                                                          |  |                                                                                                                   |  |
| 10b. COUNTY<br>CHARLES                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br>NANJEMOY                                                                                                                                                         |  |                                                                                                                   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10e. STREET AND NUMBER<br>#3711 CHINQUAPIN ROAD                                                                                                                                                 |  |                                                                                                                   |  |
| 10f. ZIP CODE<br>20662                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10g. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES                                                                                                                                                  |  |                                                                                                                   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>1960-1963                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK                                               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12TH GRADE                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CONSTRUCTION                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>GOVERNMENT                                                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>RUFUS WASHINGTON                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>DOROTHY C. DYSON WASHINGTON                                                                                                                |  |                                                                                                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>LOLA CARTER                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>#3711 CHINQUAPIN ROAD, NANJEMOY, MARYLAND 20662                                                |  |                                                                                                                   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MARYLAND VETERAN CEMETERY 11/21/95                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 20c. LOCATION — City or Town, State<br>CHELTENHAM, MARYLAND                                                                                                                                     |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lydia C. Thornton Johnson</i><br>LYDIA C. THORNTON JOHNSON MO0583 |  |
| 22. NAME AND ADDRESS OF FACILITY<br>THORNTON FUNERAL HOME, P.A.<br>3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640                                                                                                                                                                                                                                                                                                              |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>CARCINOMA LUNG</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br>1 YR |  |                                                                                                                                                                                                 |  |                                                                                                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO             |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                 |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                          |  | 28b. TIME OF INJURY<br>M                                                                                          |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                             |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                      |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                 |  |                                                                                                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>L. Carter</i>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 29c. LICENSE NUMBER<br>D-44436                                                                                                                                                                  |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/16/95                                                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ashvinkumar Patel, MD 603 Post Office Rd. Suite 207 Waldorf, Md. 20602                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                 |  |                                                                                                                   |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 20 1995                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>                                                                                                                                       |  |                                                                                                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>GEORGE ST. CLAIR WILSON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 4, 1995                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  | 3. TIME OF DEATH<br>10:17 PM                                                                |                                                |                                                                     |  |                                                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br>178-16-1821                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                      |  | 6. AGE (In yrs. last birthday)<br>79 YRS.                                                                                                                                                                                                                                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                  |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                              |                                                | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>OCT. 31, 1916             |  | 8. BIRTHPLACE (State or Foreign Country)<br>PA                                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>VA Medical Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Perry Point                                                                                                                                              |  |                                                                                             |                                                |                                                                     |  | 9c. COUNTY OF DEATH<br>Cecil                                                                    |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |
| 10a. STATE<br>PA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                 |  | 10b. COUNTY<br>YORK                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br>DELTA                                                        |                                                |                                                                     |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1956 ATOM ROAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br>17314                                                                                                                                                                          |  |                                                                                             |                                                | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                |  |                                                                                                 |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |                                                                                                                                                                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |                                                                                             |                                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE |  |                                                                                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                 |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>MECHANIC                                                                                                                                                                      |  |                                                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br>AUTOMOBILEE                                               |                                                |                                                                     |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN B. WILSON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>DORA THOMPSON                                                                                                                              |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MYRTLE M. WILSON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1956 ATOM ROAD, DELTA, PA 17314                                                                |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MT. NEBO CEMETERY 11/9/95                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br>DELTA, PA 17314                                      |                                                |                                                                     |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br>HARKINS F.H. INC., DELTA, PA 17314                                                                                                                          |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Hemorrhage<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br>2 Weeks<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                 |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                | 28d. DESCRIBE HOW INJURY OCCURRED                                   |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                 |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |                                                |                                                                     |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                           |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Manuel Ramos, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br>D38950                                                                                                                                                                   |  |                                                                                             | 29d. DATE SIGNED (Month, Day, Year)<br>11/4/95 |                                                                     |  |                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Manuel Ramos, M.D. VA Medical Center, Perry Point, MD 21902                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 8 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                 |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                             |                                                |                                                                     |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



asp

ITEMS: 23 PART I, II, 27, PER MEO FILM G-730 12/6/95 t.t

95 36239

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                     |                                                                                                           |                                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>AKAGAN A. WATTERS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            | 2. DATE OF DEATH<br>MONTH <b>OCTOBER</b> DAY <b>02</b> YEAR <b>1995</b>                                                      |                                                                                                                                                                                                     |  | 3. TIME OF DEATH<br><b>10:03 P</b>                                                   |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 4. SOCIAL SECURITY NUMBER<br><b>218-41-5910</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |                                                                                                                              | 8. AGE (In yrs. last birthday)<br><b>1</b> YRS.                                                                                                                                                     |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                     |                                                                                                     | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                                                          |                                                                                                                                                        |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>HARFORD MEMORIAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>HAVRE DE GRACE</b>                                                                 |                                                                                                                                                                                                     |  | 9c. COUNTY OF DEATH<br><b>HARFORD</b>                                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Harford</b>                                                                                                                                                                                                                                                                              |                                                                                                                              | 10c. CITY, TOWN OR LOCATION<br><b>Edgewood</b>                                                                                                                                                      |  |                                                                                      | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                           |                                                                                                                                                        |
| 10e. STREET AND NUMBER<br><b>821 Fisherman Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              | 10f. ZIP CODE<br><b>21040</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                          |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |                                                                                                                              | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>           |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>None</b> |                                                                                                                                                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>                                         |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Brance</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Yolanda O. Watters</b>                                                                                                                      |  |                                                                                      |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Yolanda O. Watters</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>821 Fisherman Lane, Edgewood, Md. 21040</b>                                                     |  |                                                                                      |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Harford Memorial Gar 10/9</b>                                                                                                                                                                                        |                                                                                                                              | DATE<br><b>10/9</b>                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br><b>Aldino, Maryland</b>                       |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles M. Reed</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              | 22. NAME AND ADDRESS OF FACILITY<br><b>552 Lewis Street<br/>Havre De Grace, Maryland 21078</b>                                                                                                      |  |                                                                                      |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDITIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                     | Approximate Interval Between Onset and Death                                                              |                                                                                                                                                        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HEMOPHILIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                              |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                                                                                                              | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                     | 28d. DESCRIBE HOW INJURY OCCURRED                                                                         |                                                                                                                                                        |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                      |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John A. [Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              | 29c. LICENSE NUMBER<br><b>O.C.M.E</b>                                                                                                                                                               |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>OCTOBER 04, 1995</b>                       |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 13 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                              | 32. REGISTRAR'S SIGNATURE<br><i>John A. [Signature]</i>                                                                                                                                             |  |                                                                                      |                                                                                                     |                                                                                                           |                                                                                                                                                        |

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36240

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ERVEL WESLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 14, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>9.05P M</b>                                                                  |                                                                                                                                                        |
| 4. SOCIAL SECURITY NUMBER<br><b>579-12-6336</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   |  | 8. AGE (In yrs. last birthday)<br><b>74</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 4, 1921</b>                                          |                                                                                                                                                        |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Prince George's Medical Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cheverly</b>                                                                                                                                              |  | 9c. COUNTY OF DEATH<br><b>Prince George's</b>                                                       |                                                                                                                                                        |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. COUNTY<br><b>Anne Arundel</b>                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Harwood</b>                                                                                                                                                       |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                                        |
| 10e. STREET AND NUMBER<br><b>4747-B Flanders Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 10f. ZIP CODE<br><b>20776</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                      |                                                                                                                                                        |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |                                                                                                                                                        |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (8-12)</b><br><b>11</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>                                                                                                                                                   |  |                                                                                                     |                                                                                                                                                        |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert Morris Milburn</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sally Pindell Dove</b>                                                                                                                      |  |                                                                                                     |                                                                                                                                                        |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lawrence Wesley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1508-E Flanders Lane Harwood, Maryland 20776</b>                                                |  |                                                                                                     |                                                                                                                                                        |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery 11/20/95</b>                         |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Maryland</b>                                                                                                                                   |  |                                                                                                     |                                                                                                                                                        |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>W.B. Gena</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Francis Gasch's Sons Funeral Home, P.A.<br/>4739 Baltimore Ave. Hyattsville, MD 20781</b>                                                                    |  |                                                                                                     |                                                                                                                                                        |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. POSSIBLE ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate interval Between Onset and Death                                                                                                           |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                           |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |                                                                                                                                                        |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M. S. Nayar</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>D-17874</b>                                                                                                                                                               |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-15-95</b>                                              |                                                                                                                                                        |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SANKARAN M. NAYAR, MD. 3717-38th Ave Cottage CUM, MD 20722</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Shuster</b>                                                                                                                                                    |  |                                                                                                     |                                                                                                                                                        |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Antarctica 1954-1955

95 36241

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                           |  |                                                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MICHAEL S. WILDONER</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 12, 1995</b>                                                                                                                                            |  | 3. TIME OF DEATH<br><b>6 00A M</b>                                                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212 64 7746</b>                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                |  | 6. AGE (In yrs. last birthday)<br><b>40</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN.                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 13, 1955</b>                                                                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Cheverly Md.</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>Prince George's Hospital</b>                                                                                                          |  |                                                                                                                                        |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br><b>Cheverly</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. COUNTY OF DEATH<br><b>Prince George's</b>                                                                                                                                                             |  |                                                                                                                                        |  |
| 12. RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 13. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                            |  |                                                                                                                                        |  |
| 14. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                 |  | 15. COUNTY<br><b>Prince George's</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16. CITY, TOWN OR LOCATION<br><b>Bowie</b>                                                                                                                                                                |  | 17. ZIP CODE<br><b>20720</b>                                                                                                           |  |
| 18. STREET AND NUMBER<br><b>6722 Willow Creek Road</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                                      |  |                                                                                                                                        |  |
| 20. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                               |  | 21. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                           |  | 22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>No</b> |  | 23. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                |  |
| 24. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>                                                                                                                                                                                                                                                     |  | 25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Mail Clerk</b>                                                                                                                                                                                                                                                                                                                                                            |  | 26. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Postal Service</b>                                                                                                                                               |  |                                                                                                                                        |  |
| 27. FATHER'S NAME (First, Middle, Last)<br><b>Alfred Wildoner</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret Humphries</b>                                                                                                                            |  |                                                                                                                                        |  |
| 29. INFORMANT'S NAME (Type/Print)<br><b>Beverly Wildoner</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6722 Willow Creek Rd. Bowie Maryland 20720</b>                                                         |  |                                                                                                                                        |  |
| 31. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                         |  | 32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery 11/15/95</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 33. LOCATION — City or Town, State<br><b>Brentwood Maryland</b>                                                                                                                                           |  | 34. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert E. Evans Pres</b>                                                               |  |
| 35. NAME AND ADDRESS OF FACILITY<br><b>Robert E. Evans Funeral Home, P.A.<br/>16000 Annapolis Rd. Bowie Md. 20715</b>                                                                                                                                                                                                                                        |  | 36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>HEPATORENAL SYNDROME</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>END STAGE LIVER CIRRHOSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>CHRONIC ALCOHOL ABUSE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><b>48 HRS</b> |  |                                                                                                                                                                                                           |  |                                                                                                                                        |  |
| 37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HEPATIC ENCEPHALOPATHY, SPONTANEOUS BACTERIAL PERITONITIS</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 38. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                      |  | 39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 40. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                            |  | 41. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                            |  |                                                                                                                                                                                                           |  |                                                                                                                                        |  |
| 42. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined                                                                          |  | 43. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 44. TIME OF INJURY<br><b>M</b>                                                                                                                                                                            |  | 45. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                        |  |
| 46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                        |  | 47. DESCRIBE NOW INJURY OCCURED                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                           |  |                                                                                                                                        |  |
| 48. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                  |  | 49. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                           |  |                                                                                                                                                                                                           |  |                                                                                                                                        |  |
| 50. SIGNATURE AND TITLE OF CERTIFIER<br><b>Joseph L. Gervais, MD</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 51. LICENSE NUMBER<br><b>D31345</b>                                                                                                                                                                       |  | 52. DATE SIGNED (Month, Day, Year)<br><b>11-12-95</b>                                                                                  |  |
| 53. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NAPOLEON C. MARCELO, MD 4000 MITCHELLVILLE RD B430 BOWIE MD 20716</b>                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                           |  |                                                                                                                                        |  |
| 54. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                      |  | 55. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rosell</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                           |  |                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36242

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Dorothy Jean Wolfe</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 13 1995</b>                                                                                                                                                                                                                                                  |  | 3. TIME OF DEATH<br><b>2:14 AM</b>                                                                                                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>354 14 8566</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.                                                                                                                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 18, 1912</b>                                                                                                                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Anne Arundel Medical Center</b>                                                                                                                                                                                                       |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>                                                                                                                                |  |
| 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><b>Anne Arundel</b>                                                                                                                                                     |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Crofton</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                        |  | 10e. STREET AND NUMBER<br><b>1772 Regents Park Road W.</b>                                                                                                                             |  |
| 10f. ZIP CODE<br><b>21114</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                                                                                                                                      |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>No</b>                                                                                                                                                                                                                                                                    |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <b>No</b>                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>School Teacher</b>                                                                                                                                                                        |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Public</b>                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Hill Jones</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maude Covert</b>                                                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Clair E. Wolfe</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1772 Regents Park W. Crofton Maryland 21114</b>                                                                                                                                                        |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                       |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Pine Grove Cemetery 11/18/95</b>                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><b>Berwick Pennsylvania</b>                                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert E. Evans Pres</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert E. Evans Funeral Home, P.A.<br/>16000 Annapolis Rd. Bowie Md. 20715</b>                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory arrest</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>Cardiovascular accident</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>pneumonia</b><br><b>urosepsis</b>                                                                                                                                                                                                                                                                   |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                        |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Liborsey</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 29c. LICENSE NUMBER<br><b>025134</b>                                                                                                                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/14/95</b>                                                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CAROL A. PRESSEY MD 1684 VILLAGE GREEN CROFTON MD 21114</b>                                                                                                                                                                                                                                                                            |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Anniston Randall</b>                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANDRE CARLYLE WILSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>13</b> YEAR <b>1995</b>                                                                                                                              |  | 3. TIME OF DEATH<br><b>4:05 P.M.</b>                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-66-0562</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>46</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7/16/49</b>                                                                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Malcolm Grow AAFB</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Camp Springs</b>                                                                                                                                      |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b>                                                                                           |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>Prince George's</b>                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Landover</b>                                                                                          |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 10e. STREET AND NUMBER<br><b>2235 Columbia Place</b>                                                                                                                                            |  |                                                                                                                                         |  |
| 10f. ZIP CODE<br><b>20785</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                  |  |                                                                                                                                         |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                 |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Budget Analyst</b>                                                                                                                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Government</b>                                                                                                                                             |  |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harvey Wilson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mattie Belle Shoutz</b>                                                                                                                 |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Carol Wilson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2235 Columbia Place, Landover, MD 20785</b>                                                 |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory 11/18 Beltsville, MD</b>                                                                                                                                                         |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  | 20d. DATE                                                                                                                               |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Juawana Braxton</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>J.B. Jenkins Funeral Home 7474 Landover Rd, Landover 20785</b>                                                                                           |  |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Generalized Atherosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>years</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>years</b><br><b>c. Chronic Renal Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>years</b><br><b>d.</b> |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  | Approximate Interval Between Onset and Death<br><b>years</b><br><b>years</b><br><b>years</b>                                            |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Artery Disease, Renal Dialysis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N                                                                                       |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Benjamin MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>D25925</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 14, 1995</b>                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. BERGER #205, 7720 WISCONSIN Ave, Bethesda, Md 20814</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>                                                                                                                                                 |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000 51 400

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |                                                  |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT WILSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |                                                  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>12</b> YEAR <b>1995</b>                                                                                                                        |  |                                                                                             |  | 3. TIME OF DEATH<br><b>1:05A</b>                                                                                                                                                                                                                                                               |  |                                                             |
| 4. SOCIAL SECURITY NUMBER<br><b>214-34-6658</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                   | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                                                                                                |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                                            |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>February 14, 1917</b>                                                                                                                                                                                                                             |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b> |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Larkin Chase Health Care Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bowie</b>                                                                                                                                             |  |                                                                                             |  | 9c. COUNTY OF DEATH<br><b>Prince George's</b>                                                                                                                                                                                                                                                  |  |                                                             |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                                  |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                             |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br><b>Prince George</b>                                                                                                          |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>New Carrollton</b>                                                                                                                                            |  |                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                |  |                                                             |
| 10e. STREET AND NUMBER<br><b>8317 Cathedral Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |                                                  | 10f. ZIP CODE<br><b>20784</b>                                                                                                                                                                   |  |                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                 |  |                                                             |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |                                                                                             |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                        |  |                                                             |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 6th</b> <b>College (1-4 or 5+) 6th</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |                                                  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Farmer</b>                                                                  |  |                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private</b>                                                                                                                                                                                                                                               |  |                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Richard Wilson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Powell</b>                                                                                                                         |  |                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marville Wilson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9027 Walkerton Drive, Lanham, MD 20706</b>                                                  |  |                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                             |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                                  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Crews United Methodist Church Cemetery 11/17</b>                                                          |  | DATE<br><b>11/17</b>                                                                        |  | 20c. LOCATION — City or Town, State<br><b>Owensville, Maryland</b>                                                                                                                                                                                                                             |  |                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Juawana L. Baxton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>J.B. JENKINS FUNERAL HOME<br/>7474 LANDOVER ROAD LANDOVER, MD 20785</b>                                                                                  |  |                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Atherosclerotic Heart Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Chronic Obstructive Pulmonary Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. _____ |  |                                                                                                                                              |                                                  |                                                                                                                                                                                                 |  |                                                                                             |  | Approximate Interval Between Onset and Death<br><b>6/93</b><br><b>6/93</b><br><b>6/93</b>                                                                                                                                                                                                      |  |                                                             |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ALZHEIMER'S Disease</b><br><b>Dysphagia</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |                                                  |                                                                                                                                                                                                 |  |                                                                                             |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                          |  |                                                             |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |                                                  |                                                                                                                                                                                                 |  |                                                                                             |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                             |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                    |                                                  | 28b. TIME OF INJURY<br>M <b>11</b>                                                                                                                                                              |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                             |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |                                                  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Rakesh Arora, MD</b>                                                                                                                                |  |                                                                                             |  | 29c. LICENSE NUMBER<br><b>D20108</b>                                                                                                                                                                                                                                                           |  |                                                             |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/95</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |                                                  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RAKESH ARORA, MD, 14300 GALLANT FOX LN # 222, BOWIE</b>                                               |  |                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                             |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |                                                  | 32. REGISTRAR'S SIGNATURE<br><b>J. B. Jenkins</b><br><b>MD 20715</b>                                                                                                                            |  |                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1970-71 1000

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EUGENE M. WINDSOR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 8, 1995</b>                                                                                                                                       |  | 3. TIME OF DEATH<br><b>9:00 P M</b>                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-82-7056</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>36</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 26, 1959</b>                                |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CHEVERLY</b>                                                                                                                                          |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGES</b>                                                |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>Prince George's</b>                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Hyattsville</b>                                           |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10e. STREET AND NUMBER<br><b>3326 Lancer Drive Apt. # 3</b>                                                                                                                                     |  |                                                                                             |  |
| 10f. ZIP CODE<br><b>20782</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                  |  |                                                                                             |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Truck Driver</b>                                                                                                                                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>S &amp; T Design</b>                                                                                                                                       |  |                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Irving W. Windsor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>June E. Milburn</b>                                                                                                                     |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Irving W. Windsor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9125 Kinzer Street, Lanham, Maryland 20706</b>                                              |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Funeral Ser. 11/10/95 Alexandria, Va.</b>                                                                                                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  | 20d. DATE                                                                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Henry S. Ford</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Francis Gasch's Sons Funeral Home, 4739 Baltimore Ave., Hyattsville, Md. 20781</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Injuries</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                 |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11/7/95</b>                                                                                                                                                                                                                                                                                                                                                    |  | 28b. TIME OF INJURY<br><b>1800 M</b>                                                                                                                                                            |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Driver in auto accident</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>INTERSECTION</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>Rt. 765 and 497</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 29a. CERTIFIER<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Locke MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>O.C.M.E</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 9, 1995</b>                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOHN LOCKE MD 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 13 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>                                                                                                                                       |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36246

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Everett James Warwick                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 5, 1995                                                                                                                                              |  | 3. TIME OF DEATH<br>12:10 AM                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br>334-10-1193                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>78 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>May 2, 1917                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Hospital                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick                                                                                                                                                    |  | 9c. COUNTY OF DEATH<br>Frederick                                                     |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br>Frederick                                                                                                                                                                            |  | 10c. CITY, TOWN OR LOCATION<br>Frederick                                             |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 10e. STREET AND NUMBER<br>5820 Genesis Lane #531                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21703                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                              |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>5+                                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Research Scientist                                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br>U.S. Department of Agriculture                                                                                                                                    |  |                                                                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Paul M. Warwick                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Bernice Ramsey                                                                                                                                 |  |                                                                                      |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Esther J. Warwick                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5820 Genesis Lane #531, Frederick, MD 21703                                                        |  |                                                                                      |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Aledo Cemetery 11/11/95                                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br>Aledo, Illinois                                                                                                                                              |  |                                                                                      |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>H. Constance Gasch                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Ave., Hyattsville, MD 20781                                                                           |  |                                                                                      |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  | a. <u>CACHEXIA</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>DEMENTIA</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>ALUMINUM TOXICITY</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <u>RENAL FAILURE</u>                                                                                             |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                          |  | Approximate Interval Between Onset and Death<br>3 mo<br>6 mo<br>1 yr<br>8 yr                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |                                                                                      |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                      |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>D29591                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/15/95                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARK A RUBIN 56 Thomas Johnson Drive Frederick MD 21702                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 13 1995                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson Randall                                                                                                                                                  |  |                                                                                      |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36247

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARIE ANTOINETTE WOODYARD</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>10</b> YEAR <b>1995</b>                                                                                                                                                                                                                                                                                                                                                    |  | 3. TIME OF DEATH<br><b>4:00 A M</b>                                                                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-32-2585</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.                                                                                                                                                                                                                                                                                                                                                                            |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Nov. 28, 1926</b>                                                                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>8517 58th Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Berwyn Heights</b>                                                                                                                                                                                                                                                                                                                                                                |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b>                                                                                                      |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Prince George's</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 10c. CITY, TOWN OR LOCATION<br><b>Berwyn Heights</b>                                                                                               |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>8517 58th Avenue</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                    |  |
| 10f. ZIP CODE<br><b>20740</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                    |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                             |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Clerk</b>                                                                                                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Machinist Union</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Antonio D'Agostino</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Filomena Gentilcore</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Anthony R. Carroll</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5503 Lake Ridge Terrace, Bowie, Maryland 20720</b>                                                                                                                                                                                                                                                                      |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery 11/14/95</b>                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Maryland</b>                                                                                                                                                                                                                                                                                                                                                           |  | 20d. DATE<br><b>11/14/95</b>                                                                                                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Henry S. Land</i>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Francis Gasch's Sons Funeral Home, P.A.<br/>4739 Baltimore Ave., Hyattsville, MD 20781</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. HYPERTENSION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | Approximate Interval Between Onset and Death<br><b>Seconds</b><br><b>years</b>                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                    |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                    |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Berger MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D25925</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 10, 1995</b>                                                                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. BERGER MD #205, 7720 WISCONSIN AVE, BETHESDA, MD 20814</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 13 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Berger</i>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                    |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36248

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |                                                                                                                                              |                                                                                                                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>LOUIS Wheeler</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 4, 1995</b>                                                                                                                                                                                                                                  |                                                                                                                                                   | 3. TIME OF DEATH<br>M<br><b>10:10 PM</b>                                                                                                     |                                                                                                                                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br><b>578-70-9784</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>42</b> YRS.                                                                                                                                                                                                                                               | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb 26 1953</b>                                                                                      | 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington, DC</b>                                                                            |                                                                                                                                                                                                                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3901 Suitland Rd #1606</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Suitland, Maryland</b>                                                                                                                                                                                                                               |                                                                                                                                                   | 9c. COUNTY OF DEATH<br><b>Prince Georges</b>                                                                                                 |                                                                                                                                                                                                                                                             |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 10b. COUNTY<br><b>Prince Georges</b>                                                                                                                                                                                                                                                           |                                                                                                                                                   | 10c. CITY, TOWN OR LOCATION<br><b>Suitland, Maryland</b>                                                                                     |                                                                                                                                                                                                                                                             |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | 10e. STREET AND NUMBER<br><b>3901 Suitland Road #1606</b>                                                                                                                                                                                                                                      |                                                                                                                                                   | 10f. ZIP CODE<br><b>20746</b>                                                                                                                |                                                                                                                                                                                                                                                             |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                 |                                                                                                                                                   | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                                                                                                                                                                                                                                             |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                        |                                                                                                                                                   | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |                                                                                                                                                                                                                                                             |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>CHEF</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Food Industry</b>                                                                                                                                                                                                                                         |                                                                                                                                                   |                                                                                                                                              |                                                                                                                                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Raymond I. Stewart</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                                                                                                                                                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Wheeler</b>                                                                          |                                                                                                                                              |                                                                                                                                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Wheeler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3901 Suitland Rd #1606 Suitland, MD 20746</b> |                                                                                                                                              |                                                                                                                                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Washington National 11/10</b>                                                                                                                                                                            |                                                                                                                                                   | 20c. LOCATION — City or Town, State<br><b>Suitland, MD</b>                                                                                   |                                                                                                                                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Alex. S. Pope, Jr.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                                | 22. NAME AND ADDRESS OF FACILITY<br><b>Alexander S. Pope Funeral Homes<br/>2617 Penn Ave SE Washington, DC 20020</b>                              |                                                                                                                                              |                                                                                                                                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute pulmonary arrest</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>End stage 8 AIDS</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |                                                                            |                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |                                                                                                                                              | Approximate Interval Between Onset and Death                                                                                                                                                                                                                |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |                                                                                                                                              | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                                                                                                                              |                                                                                                                                                                                                                                                             |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                              |                                                                            | 28a. DATE OF INJURY (Month, Day, Year)<br><b>N/A</b>                                                                                                                                                                                                                                           | 28b. TIME OF INJURY<br><b>N/A</b> M                                                                                                               | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                  | 28d. DESCRIBE NOW INJURY OCCURRED<br><b>N/A</b>                                                                                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                               |                                                                            | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Peter O. Kwon, M.D.</i>                                                                                                                                                                                                                            |                                                                                                                                                   | 29c. LICENSE NUMBER<br><b>D24579</b>                                                                                                         | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-09-95</b>                                                                                                                                                                                                      |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Peter O. Kwon, M.D. 2041 M.L. KING AVE SE Suite LL-2 WASH. D.C. 20020</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |                                                                                                                                              |                                                                                                                                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 14 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>                                                                                                                                                                                                                                                |                                                                                                                                                   |                                                                                                                                              |                                                                                                                                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

not to be used as a guide  
CBI # 1000

95 36249

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELEN T WOLFE</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>12</b> YEAR <b>1995</b>                                                                                                                                                                                                                       |  |                                                                 |                                                                              | 3. TIME OF DEATH<br><b>11:30 A M</b>                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-74-4785</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Sept. 20, 1904</b> |                                                                              | 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington, DC</b>                               |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Suburban Hospital</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>                                                                                                                                                                                                                                         |  |                                                                 |                                                                              | 9c. COUNTY OF DEATH<br><b>Montgomery County</b>                                                 |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Montgomery County</b>                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>                                                                                                                                                                                                                                            |  |                                                                 |                                                                              | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>14626 Tynewick Terrace</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 10f. ZIP CODE<br><b>20906</b>                                                                                                                                                                                                                                                                  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>           |                                                                              |                                                                                                 |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  |                                                                 | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |                                                                                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                                                                                                                                                              |  |                                                                 | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Owned Home</b>                          |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William B. Gray</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Advent King</b>                                                                                                                                                                                                                  |  |                                                                 |                                                                              |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charlotte Pusey</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14626 Tynewick Terrace, Silver Spring, MD 20906</b>                                                                                                                                        |  |                                                                 |                                                                              |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery 11/16/95</b>                                                                                                                                                                       |  |                                                                 | 20c. LOCATION — City or Town, State<br><b>Brentwood, Maryland</b>            |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSE<br>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Fort Lincoln Funeral Home, Inc.<br/>3401 Bladensburg Road, Brentwood, MD 20722</b>                                                                                                                                                                      |  |                                                                 |                                                                              |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Heart Disease 10 years</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>Diabetes mellitus 20 years</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Acute cholecystitis; acute myocardial infarction</b>                                                                                                                                                                                                                                            |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                 |                                                                              |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                |  |                                                                                                                                              |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                 |                                                                              | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  |                                                                 | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  | 29c. LICENSE NUMBER<br><b>708546</b>                                                                                                                                                                                                                                                           |  |                                                                 | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov. 12, 95</b>                    |                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John Tauer 821 Wisconsin Ave Bethesda Md.</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                 |                                                                              |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 14 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                  |  |                                                                 |                                                                              |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

212



95 36250

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                             |  |                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EUGENE F. WILLIAMSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>12</b> YEAR <b>1995</b>                                                                                                                                                                                                                       |  |                                                                                             |  | 3. TIME OF DEATH<br><b>11-10 A</b>                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>548-26-1247</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>March 29, 1916</b>                             |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>New Jersey</b>                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CHINTON</b>                                                                                                                                                                                                                                          |  |                                                                                             |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGE</b>                                                                   |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br><b>Prince George's</b>                                                                                                        |  | 10c. CITY, TOWN OR LOCATION<br><b>District Heights</b>                                                                                                                                                                                                                                         |  |                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO               |  |
| 10e. STREET AND NUMBER<br><b>6704 Foster Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 10f. ZIP CODE<br><b>20747</b>                                                                                                                                                                                                                                                                  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                 |  |                                                                                                               |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |                                                                                                               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8th</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Owner</b>                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Television Repair Shops</b>                                                                                                                                                                                                                               |  |                                                                                             |  |                                                                                                               |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frederick R. Williamson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Alice Mundy</b>                                                                                                                                                                                                                   |  |                                                                                             |  |                                                                                                               |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lena O. Williamson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6704 Foster St. District Heights, Md. 20747</b>                                                                                                                                            |  |                                                                                             |  |                                                                                                               |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory 11-13-95</b>                    |  | 20c. LOCATION — City or Town, State<br><b>Alexandria, Virginia</b>                                                                                                                                                                                                                             |  |                                                                                             |  |                                                                                                               |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>George P. Kalas Funeral Home<br/>6160 Oxon Hill Rd. Oxon Hill, Md. 20745</b>                                                                                                                                                                            |  |                                                                                             |  |                                                                                                               |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aortic occlusion</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Peripheral vascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Atherosclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>carotid artery disease</b> |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                             |  | Approximate interval between Onset and Death<br><b>4 days</b><br><br><b>long term</b><br><br><b>long term</b> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                             |  |                                                                                                               |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                       |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                         |  |                                                                                                                                              |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                      |  | 29c. LICENSE NUMBER<br><b>D29617</b>                                                        |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/95</b>                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>LISA GOLDBERG 7501 SUMMITT ROAD CHINTON MARYLAND 20735</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                             |  |                                                                                                               |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 14 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                  |  |                                                                                             |  |                                                                                                               |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36251

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Fu Hsia You                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 15 1995                                                                                                                                              |  |                                                                                      |  | 3. TIME OF DEATH<br>8:30 A M                                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br>224-25-5369                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>70 YRS.                                                                                                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                       |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                                                                                         |  |
| 7. DATE OF BIRTH (Month, Day, Year)<br>April 19, 1925                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 8. BIRTHPLACE (State or Foreign Country)<br>China                                                                                                                                                   |  |                                                                                      |  |                                                                                                                                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1425 Templeton Place                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rockville                                                                                                                                                    |  |                                                                                      |  | 9c. COUNTY OF DEATH<br>Montgomery                                                                                                                      |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br>Montgomery                                                                                                                                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br>Rockville                                                                                                                                                            |  |                                                                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br>1425 Templeton Place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>20852                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                       |  |                                                                                                                                                        |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |                                                                                      |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Asian                                                                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Vice President                                                                        |  |                                                                                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Newspaper                                                                                                            |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Chung Fang You                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>You Chan Fun Ying                                                                                                                              |  |                                                                                      |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Hao Jan You                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1425 Templeton Place, Rockville, Maryland 20852                                                    |  |                                                                                      |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Nov. 19, 1995<br>Montgomery Crematorium, Inc.                                                                    |  |                                                                                      |  | 20c. LOCATION — City or Town, State<br>Bethesda, Maryland                                                                                              |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael E. Higgins</i> M00846                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue<br>Bethesda, Maryland 20814-3501                                              |  |                                                                                      |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>HEPATOMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | Approximate Interval Between Onset and Death<br>6 months                                                                                               |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                      |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                      |  |                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joseph K. ...</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>D35635                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>Nov. 15, 1995                                 |  |                                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Joseph K. ... 1811 Prince Philip Dr. Olney, MD 20832                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 16 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John ...</i>                                                                                                                                                        |  |                                                                                      |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Glena Essie Zukowski</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 6, 1995</b>                                                                                                                                       |  | 3. TIME OF DEATH<br><b>6:10 pm</b>                                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-38-9873</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan. 26, 1922</b>                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>                                              |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>Frederick</b>                                                                                                                                                                     |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>                                      |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 10e. STREET AND NUMBER<br><b>1241 Danielle Drive</b>                                                                                                                                                |  |                                                                                      |  |
| 10f. ZIP CODE<br><b>21702</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                               |  |                                                                                      |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Crossing Guard</b>                                                                                                                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Montgomery Co. Police Dept.</b>                                                                                                                                |  |                                                                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Howard Hemenway</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Essie Swanton</b>                                                                                                                           |  |                                                                                      |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Bonnie Turner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>615 Edmonston Drive, Rockville, MD 20851</b>                                                    |  |                                                                                      |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Mary's Cemetery 11/10/95</b>                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><b>Rockville, Maryland</b>                                                                                                                                   |  | 20d. LOCATION — City or Town, State<br><b>Rockville, Maryland</b>                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael D. Gibbons</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DeVol Funeral Home</b><br><b>10 East Deer Park Drive</b><br><b>Gaithersburg, MD 20877</b>                                                                    |  |                                                                                      |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. <i>Amelanotic melanoma, metastatic</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. <i>chronic renal failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. <i>Dehydration</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. <i>Lymphedema @ leg</i> |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                      |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Eugene Casagrande MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D40307</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/7/95</b>                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Eugene Casagrande M.D., Parkview Medical Center, Frederick, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 13 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson Randall</i>                                                                                                                                          |  |                                                                                      |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


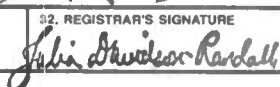
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

08 00525

95 36253

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Athenia J. Zieske</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 6, 1995</b>                                                                                                                                       |  | 3. TIME OF DEATH<br><b>2:15 P M</b>                                                                 |                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br><b>579-18-0867</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                                                                         |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Mar. 29, 1920</b>                                         |                                                                                                                                             |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington, D.C.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>14905 Emory Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                            |                                                                                                                                             |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                                                                                                                                        |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                             |
| 10e. STREET AND NUMBER<br><b>14905 Emory Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  | 10f. ZIP CODE<br><b>20853</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                         |                                                                                                                                             |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |                                                                                                                                             |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>                                                                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Federal Government</b>                                         |                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Zacharias G. Jalepes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Economides</b>                                                                                                                         |  |                                                                                                     |                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Clifford C. Zieske</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14905 Emory Lane, Rockville, Maryland 20853</b>                                                 |  |                                                                                                     |                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery 11/10 Brentwood, Maryland</b>                                                                                                                                                               |  | 20c. LOCATION — City or Town, State                                                                                                                                                                 |  |                                                                                                     |                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hines-Rinaldi Funeral Home<br/>11800 New Hampshire Avenue<br/>Silver Spring, Maryland 20904</b>                                                              |  |                                                                                                     |                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Brain metastases</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Colon carcinoma</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Carcinoma of the breast</b> |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death<br><b>4 months</b><br><b>7 years</b>                                                           |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Carcinoma of the breast</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28d. DESCRIBE HOW INJURY OCCURED                                                                                                                                                                                                                                                                        |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Israel Spector MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br><b>D11200</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 7 1995</b>                                            |                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Israel Spector MD 12001 Ferrara Ave Wheaton Md 20906</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 13 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                    |  |                                                                                                     |                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95-6841-031  
B.K.S

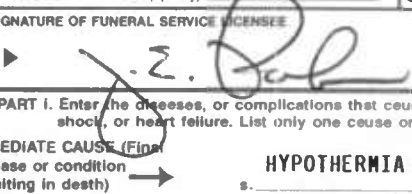
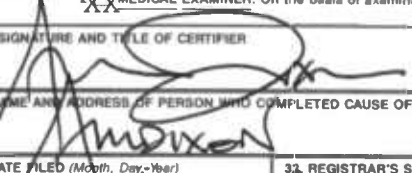

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-730 12/7/95 t.t

95 36254

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DEBORAH LEE ZIMMERMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 10, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>9:30 A M</b>                                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-64-6393</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                |  | 6. AGE (In yrs. last birthday)<br><b>42</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>August 15, 1953</b>                                                                                                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New Mexico</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                           |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>18501 CINNAMON DRIVE</b>                                                                                                   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>GERMANTOWN</b>                                                                                                                       |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                           |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                   |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                               |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Germantown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                           |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>18604 Bay Leaf Way</b>                                                                                                                            |  |
| 10f. ZIP CODE<br><b>20874</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                           |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                           |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |                                                                                                                                                                                |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                           |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>                                                            |  |                                                                                                                                                                                |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government</b>                                                                                                                                        |  |                                                                                                                                                                                |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert Zimmerman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Dorothy Lee Caruthers</b>                                                                                                               |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert Zimmerman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14417 Bauer Drive, Rockville, Maryland 20853</b>                                            |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                           |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery 11/14 Silver Spring, Maryland</b>                                                 |  |                                                                                                                                                                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                           |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DeVol Funeral Home<br/>10 E. Deer Park Dr., Gaithersburg, MD 20877</b>                                                                                   |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>HYPOTHERMIA COMPLICATING ALCOHOL AND DRUG INTOXICATION</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                           |  |                                                                                                                                                                                                 |  | Approximate Interval Between Onset and Death                                                                                                                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                           |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                          |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                           |  |                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                             |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11-10-95</b>                                                                 |  | 28b. TIME OF INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><b>7:40 A M</b>                                                                          |  | 28c. DESCRIBE HOW INJURY OCCURRED<br><b>UNKNOWN</b>                                                                                                                            |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND: ON SCHOOL GROUNDS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>18501 CINNAMON DR. GERMANTOWN, MD.</b> |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                           |  |                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                           |  | 29c. LICENSE NUMBER<br><b>O.C.M.E</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 11, 1995</b>                                                                                                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 13 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                           |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

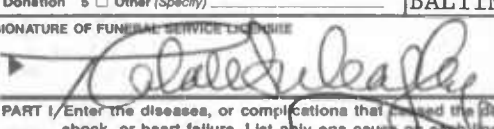
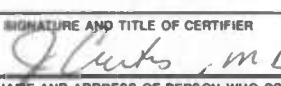

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36255

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARSHALL RAYMOND ATKINSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 22 1995</b>                                                                                                                                   |  | 3. TIME OF DEATH<br>P M<br><b>4:10 P</b>                                                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>NA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br><b>1 1</b>                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>NOVEMBER 21, 95 VIRGINIA</b>                                                               |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>                                                                                                                                          |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>                                                                                                |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 10a. STATE<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>PRINCE WILLIAM</b>                                                                                                                                                                                                                                                        |  | 10c. CITY, TOWN OR LOCATION<br><b>TRIANGLE</b>                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><b>18150 KILMER LANE T-1</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><b>22172</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>N/A</b>                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>                                                                                            |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>RICHARD M. ATKINSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MICHELLE L. TEWKSBURY</b>                                                                                                               |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RICHARD M. ATKINSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3205 EAST OLIVE ROAD 3103, PENSACOLA, FLORIDA 32514</b>                                     |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BALTIMORE WASHINGTON CREM. 11/26</b>                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State<br><b>LAUREL, MARYLAND</b>                                                                                                                                  |  |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FLECK FUNERAL HOME, INC.<br/>7601 SANDY SPRING ROAD, LAUREL, MD 20707</b>                                                                                |  |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>EXTREME PREMATURITY (24 WKS)</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                    |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                                                         |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>J. CURTIS, CDR, MC, USNR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>ME-0051174 (FL)</b>                                                                                                                                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 24, 1995</b>                                                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NATIONAL NAVAL MEDICAL CENTER<br/>BETHESDA MD 20889-5600</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 3 0 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2255

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BERNICE E. ALSTON</b>                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 24 1995</b>                                                                                                                                                                                                                                                                                     |  | 3. TIME OF DEATH<br><b>6:23 A M</b>                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-28-3007</b>                                                                                                                                                                                                 |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.                                                                                                                                                                                                                                                                                             |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>DEC. 6, 1930</b>                                                                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1835 FREDERICK AVE</b>                                                                                                                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                  |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |  |
| 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10e. STREET AND NUMBER<br><b>3305 Elmley Avenue</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |  |
| 10f. ZIP CODE<br><b>21213</b>                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                 |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                          |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                       |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>—</b>                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cook</b>                                                                                                                                                                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Nursing Home</b>                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles ,Morris</b>                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian Knox</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jenny D. Williams</b>                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1213 Demarcay Way/Baltimore, MD 21224</b>                                                                                                                                                                                                |  |                                                                                                                                               |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garfield Forest VA Cem. 11-29</b>                                                                                                                                                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, MD</b>                                                                                                                                                                                                                                                                               |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sheldia Mahoney Davis</i>                                                                     |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>March Funeral Home East</b>                                                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1101 E. North Avenue/Baltimore, MD 21202</b>                                                                                                                                                                                                                                                                                                                                              |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                              |  | Approximate Interval Between Onset and Death                                                                                                  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                               |  | b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  | c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                          |  | d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                           |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                      |  | c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  | d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                          |  | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES</b>     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                       |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  | 24c. INSPECTION                                                                                                                                                                                                                                                                                                                              |  | 24d. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                        |  |
| 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                             |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                    |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TYPE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                   |  | 29c. LICENSE NUMBER<br><b>O.C.M.E</b>                                                                                                         |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 24, 1995</b>                                                                                                                                                                                      |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                          |  | 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                               |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charles Alston</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |                                           | 2. DATE OF DEATH<br>November 27, 1995                                                                                                                                                               |  | 3. TIME OF DEATH<br>11:40P M                                                                        |                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br>251-01-7969                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             | 6. AGE (In yrs. last birthday)<br>86 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>7/9/1909                                                                                                                                                     |  | 8. BIRTHPLACE (State or Foreign Country)<br>S. Carolina                                             |                                                                                                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Maryland General Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City                                                                                                                                               |  | 9c. COUNTY OF DEATH<br>Baltimore City                                                               |                                                                                                                                             |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br>N/A                                                                                                                                                                                                                                                                                         |                                           | 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                             |
| 10e. STREET AND NUMBER<br>452 Walton Court                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |                                           | 10f. ZIP CODE<br>21201                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                |                                                                                                                                             |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                    |                                                                                                                                             |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5th<br>College (1-4 or 5+) College                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Laborer                                                                                                                                                                                   |                                           | 16b. KIND OF BUSINESS/INDUSTRY<br>Construction                                                                                                                                                      |  |                                                                                                     |                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br>Andrew Alston                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ora Green                                                                                                                                      |  |                                                                                                     |                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br>Florence Alston                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>452 Walton Court, Baltimore, MD. 21201                                                             |  |                                                                                                     |                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                           |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Zion Cemetery 12/2                                                                                                                                                                                                  |                                           | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland                                                                                                                                          |  | 21207                                                                                               |                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 22. NAME AND ADDRESS OF FACILITY<br>LEROY O. DYETT & SON FUNERAL HOME<br>4600 LIBERTY HEIGHTS AVENUE 21072                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Severe Anemia<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>End Stage Renal Disease<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death                                                                                                |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                 |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                           | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |                                           | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                     |                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>W. Fakhar</i> M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |                                           | 29c. LICENSE NUMBER<br>89245                                                                                                                                                                        |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 27, 1995                                            |                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Wasim Fakhar, M.D. c/o Maryland General Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                           | 32. REGISTRAR'S SIGNATURE<br><i>Juli Anderson-Randall</i>                                                                                                                                           |  |                                                                                                     |                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36258

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDWARD L. BERRY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>27</b> YEAR <b>'95</b>                                                                                                                             |  | 3. TIME OF DEATH<br><b>1:15A</b>                                                                |                                              |
| 4. SOCIAL SECURITY NUMBER<br><b>218-42-5208</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>49</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>OCT 7 '46</b>                                      |                                              |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Medical Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                         |  | 8c. COUNTY OF DEATH<br><b>NA</b>                                                                |                                              |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                              |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br><b>NA</b>                                                                                                                                                                                                                                                                       |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                              |
| 10a. STREET AND NUMBER<br><b>4014 Fairfax Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21216</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                              |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |                                              |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>G.E.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CAB DRIVER</b>                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CAB COMPANY</b>                                                                                                                                            |  |                                                                                                 |                                              |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LOUIS BERRY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Doreess Dabney</b>                                                                                                                      |  |                                                                                                 |                                              |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARTHA BERRY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1617 MORELAND AVE. BALTO. MD. 21217</b>                                                     |  |                                                                                                 |                                              |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Western Star</b>                                                                                                                                                                                         |  | 20c. LOCATION — City or Town, State<br><b>catonsville, md</b>                                                                                                                                   |  |                                                                                                 |                                              |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Glynis B. Harris</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MARCH FUNERAL HOME - WEST 21215<br/>4300 Wabash Ave. Balto Md</b>                                                                                        |  |                                                                                                 |                                              |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>RESPIRATORY INSUFFICIENCY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>ACQUIRED IMMUNO DEFICIENCY SYNDROME</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>END STAGE RENAL DISEASE</b><br><b>ON HAEMO-DIALYSIS</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate interval Between Onset and Death |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                              |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |                                              |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                              |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>SUDHIR D. PATEL MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D 23300</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 27. 95</b>                                       |                                              |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SUDHIR D. PATEL 2600 liberty Rd. BALTO. MD. 21215</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                              |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                              |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-7188-510

AM

ITEMS: 23 PART I, 27, PER MEO FILM G-731 1/11/96 t.t  
Items 19a, 19b 11-30-95 Film G729 W.H. Per F/H

95 36259

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CALVIN LAMONT BROWN JR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 27, 1995</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 3. TIME OF DEATH<br><b>18:36 P M</b>                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-98-6537</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>15</b> YRS.                                                                                                                                                                                                                                                                                                                                                                             |  | 7. DATE OF BIRTH<br>Month, Day, Year<br><b>JUL. 7, 1980</b>                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNION MEMORIAL ER</b>                                                                                                                                                                                                                                                                                                                                   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                          |  |
| 9c. COUNTY OF DEATH<br><b>m/a</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>n/a</b>                                                        |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>2422 LOCH RAVEN ROAD</b>                            |  |
| 10f. ZIP CODE<br><b>21218</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9 th</b> College (1-4 or 5+) <b>-</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>STUDENT</b>                                                                                                                                                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HIGH SCHOOL</b>                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>KENNETH BROWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>TARNETTA PEACOCK</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DEBROAH MARTIN (2402)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street, Route Number, City or Town, State, Zip Code)<br><b>2402 LOCH RAVEN ROAD, BALTIMORE, MD 21218</b>                                                                                                                                                                                                                                                                                               |  |                                                                                  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place)<br><b>WVOSHELL MEMORIAL GARDEN 12-1 DUNDALK, MD</b>                                                                                                                                                     |  | 20c. LOCATION — City or Town, State                                                                                                                                                                                                                                                                                                                                                                                          |  | 20d. DATE                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM. C. MARCHFH.-1101 E. NORTH AVENUE</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIOMYOPATHY</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                                  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>OCME</b>                                                                                                                                                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 28, 1995</b>                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>THEODORE M. K. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36260

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                |                                                                                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Jerome Edmund Baier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |                                           | 2. DATE OF DEATH<br>MONTH 11 DAY 27 YEAR 95                                                                                                                                                         |                                | 3. TIME OF DEATH<br>6:55 A.M.                                                                                                               |  |
| 4. SOCIAL SECURITY NUMBER<br>102-12-0143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                              | 6. AGE (In yrs. last birthday)<br>72 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                      | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug 15, 1923                                                                                         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>N.Y.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                           | 9. COUNTY OF DEATH<br>Baltimore                                                                                                                                                                     |                                |                                                                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1205 Tugwell Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Catonsville                                                                                                                                                  |                                | 9c. COUNTY OF DEATH<br>Baltimore                                                                                                            |  |
| 10a. STATE<br>Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                |                                           | 10c. CITY, TOWN OR LOCATION<br>Catonsville                                                                                                                                                          |                                | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                             |  |
| 10e. STREET AND NUMBER<br>1205 Tugwell Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |                                           | 10f. ZIP CODE<br>21228                                                                                                                                                                              |                                | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                        |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                   |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                                                                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Regional Controller                                                                                                                                                                    |                                           | 16b. KIND OF BUSINESS/INDUSTRY<br>Montgomery Ward                                                                                                                                                   |                                |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Albert Baier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Eva Huether                                                                                                                                    |                                |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Katie Baier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1205 Tugwell Avenue, Catonsville, Md. 21228                                                        |                                |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Crestlawn Memorial Gardens 11/30 Balto, Md.                                                                                                                                                                          |                                           | 20c. LOCATION — City or Town, State                                                                                                                                                                 |                                |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Phillips Starks</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |                                           | 22. NAME AND ADDRESS OF FACILITY<br>Sterling Ashton Funeral Home<br>736 Edmondson Avenue, Balto, Md. 21228                                                                                          |                                |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF): HTN<br>c. DUE TO (OR AS A CONSEQUENCE OF): Crohn's Disease<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                | Approximate Interval Between Onset and Death<br>1 yr.                                                                                       |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Parkinsonism                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                     |                                |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                           | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                       |                                           | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |                                | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                |                                                                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |                                           | 29c. LICENSE NUMBER<br>036942                                                                                                                                                                       |                                | 29d. DATE SIGNED (Month, Day, Year)<br>11/27/95                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>B. TURAKHIA, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 3 0 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |                                           | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                     |                                |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12-1-10-17



95 36261

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|-----------------------------------|----------------------------------------------------------------|---------------------------------|--------------|---------------------------------|--------------|---------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CLIFFORD S. BOXENBAUM</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 25 1995</b>                                                                                                                                   |  | 3. TIME OF DEATH<br><b>3:15 P M</b>                                              |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>189-18-2395</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 15, 1914</b>                      |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                         |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 10a. STATE<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Philadelphia County</b>                                                                                                                                                       |  | 10c. CITY, TOWN OR LOCATION<br><b>Philadelphia</b>                               |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>7035 Kindred Street</b>                                                                                                                                            |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 10f. ZIP CODE<br><b>19149</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                  |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>       |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Yrs</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machinist</b>                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Honeywell Corp.</b>                                                                                                                                        |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>(Unknown) Boxenbaum</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sarah (Unknown)</b>                                                                                                                     |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rachel Boxenbaum</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7035 Kindred Street, Philadelphia, PA 19149</b>                                             |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Shalom Memorial Park 11/27/1995</b>                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br><b>Lower Moreland, PA</b>                                                                                                                                |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald C. Stettin</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.<br/>232 CARROLL ST, NW, WASHINGTON, DC 20012</b>                                                                |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><table border="1"> <tr> <td>a. <b>CORONARY ARTERY DISEASE</b></td> <td>Approximate Interval Between Onset and Death<br/><b>30 mins</b></td> </tr> <tr> <td>b. <b>CHRONIC RENAL FAILURE</b></td> <td><b>Years</b></td> </tr> <tr> <td>c. <b>CHRONIC RENAL FAILURE</b></td> <td><b>Years</b></td> </tr> <tr> <td>d. <b>CHRONIC RENAL FAILURE</b></td> <td></td> </tr> </table> |                                                                |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  | a. <b>CORONARY ARTERY DISEASE</b> | Approximate Interval Between Onset and Death<br><b>30 mins</b> | b. <b>CHRONIC RENAL FAILURE</b> | <b>Years</b> | c. <b>CHRONIC RENAL FAILURE</b> | <b>Years</b> | d. <b>CHRONIC RENAL FAILURE</b> |  |
| a. <b>CORONARY ARTERY DISEASE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Approximate Interval Between Onset and Death<br><b>30 mins</b> |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| b. <b>CHRONIC RENAL FAILURE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Years</b>                                                   |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| c. <b>CHRONIC RENAL FAILURE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Years</b>                                                   |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| d. <b>CHRONIC RENAL FAILURE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                |                                                                                                                                                                                                                                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                         |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                |                                                                                                                                                                                                                                                                                                |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John D. Martin, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D45019</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 25, 1995</b>                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOHN D. MARTIN, M.D. 9715 MEDICAL CENTER DRIVE ROCKVILLE MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 3 0 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>John D. Martin</b>                                                                                                                                              |  |                                                                                  |  |                                   |                                                                |                                 |              |                                 |              |                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used in the study.

3. The third part is a discussion of the results of the study.

4. The fourth part is a conclusion and a list of references.

5. The fifth part is a list of appendices.

6. The sixth part is a list of figures and tables.

7. The seventh part is a list of abbreviations and symbols.

8. The eighth part is a list of acknowledgments.

9. The ninth part is a list of footnotes.

10. The tenth part is a list of references.

11. The eleventh part is a list of references.

12. The twelfth part is a list of references.

13. The thirteenth part is a list of references.

14. The fourteenth part is a list of references.

15. The fifteenth part is a list of references.

16. The sixteenth part is a list of references.

17. The seventeenth part is a list of references.



95 36262

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHERNA BERNAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 27 1995</b>                                                                                                                                                                                                                                  |  | 3. TIME OF DEATH<br><b>4:00 A M</b>                                                                                                          |                                                                                                                                         |
| 4. SOCIAL SECURITY NUMBER<br><b>14-92-8590</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>89 YRS.</b>                                                                                             |                                                                                                                                         |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>JAN. 27, 1906</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>RUSSIA</b>                                                                                                                                                                                                                                      |  |                                                                                                                                              |                                                                                                                                         |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LEVINDALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                            |                                                                                                                                         |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                              |                                                                                                                                         |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10e. STREET AND NUMBER<br><b>5900 PARK HEIGHTS AVE., APT. 210</b>                                                                                                                                                                                                                              |  | 10f. ZIP CODE<br><b>21215</b>                                                                                                                |                                                                                                                                         |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                                                                                                                         |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                                                                                                                                                                                                                     |  |                                                                                                                                              |                                                                                                                                         |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>                                                                                            |                                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>AZIK ZASCAVSKY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MIRIAM CHAIA KIKSMAN</b>                                                                                                                                                                                                               |  |                                                                                                                                              |                                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MR. GRIGROY BERMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5906 PARK HTS AVE., APT. 309 BALTIMORE, MD 21215</b>                                                                                                                                       |  |                                                                                                                                              |                                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARLINGTON-CHIZUK AMUNO 11-28-1995- BALTIMORE, MD</b>                                                                                                                                                     |  | 20c. LOCATION — City or Town, State                                                                                                          |                                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott M. Cutler</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>                                                                                                                                                                       |  |                                                                                                                                              |                                                                                                                                         |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aspiration Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Dementia - Alzheimer's Type</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              | Approximate Interval Between Onset and Death<br><b>2 days years</b>                                                                     |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Angina<br/>Atherosclerosis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                              |                                                                                                                                         |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide                                                                                                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                              |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                    |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                            |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                 |                                                                                                                                         |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                                                                                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Debra S. Wertheimer MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 29c. LICENSE NUMBER<br><b>D23767</b>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 27, 1995</b>                                                                              |                                                                                                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DEBRA S. WERTHEIMER MD 2434 W. Belvedere Ave. Balt. MD 21215</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Anderson</i>                                                                                                                                                                                                                                           |  |                                                                                                                                              |                                                                                                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36263

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Franklin Adam Baier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 28 1995                                                                                                                                                  |  | 3. TIME OF DEATH<br>9:18 A.M.                                                        |                                                                                                                                                        |
| 4. SOCIAL SECURITY NUMBER<br>213-09-0412                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br>86 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 30, 1909                              |                                                                                                                                                        |
| 9a. FACILITY NAME (If not institution, give street and number)<br>815 S. Clinton Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                                                                                                                                    |  | 9c. COUNTY OF DEATH<br>N/A                                                           |                                                                                                                                                        |
| 10a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br>N/A                                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore                                             |                                                                                                                                                        |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |
| 10e. STREET AND NUMBER<br>815 S. Clinton Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  | 10f. ZIP CODE<br>21224                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                              |                                                                                                                                                        |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |                                                                                                                                                        |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (14 or 5+) 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Mill Wright                                                                                                                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Bethlehem Steel                                                                                                                                                   |  |                                                                                      |                                                                                                                                                        |
| 17. FATHER'S NAME (First, Middle, Last)<br>George G. Baier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ella Wylie                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |
| 19a. INFORMANT'S NAME (Type/Print)<br>Helen J. Baier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>815 S. Clinton Street, Balto., Md. 21224                                                           |  |                                                                                      |                                                                                                                                                        |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Sacred Heart of Jesus Cem. 12/2                                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.                                                                                                                                               |  |                                                                                      |                                                                                                                                                        |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  | 22. NAME AND ADDRESS OF FACILITY<br>21224<br>Lilly & Zeiler Inc. 700 S. Conkling St.                                                                                                                |  |                                                                                      |                                                                                                                                                        |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Hypertension<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      | Approximate Interval Between Onset and Death                                                                                                           |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                                        |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                      |                                                                                                                                                        |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br>K41399                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/29/95                                      |                                                                                                                                                        |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>THEODORE STEPHENS, MD, 1576 Merritt Blvd, Ste 17, Balt, MD 21222                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                       |  |                                                                                      |                                                                                                                                                        |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



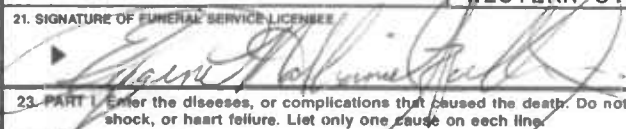
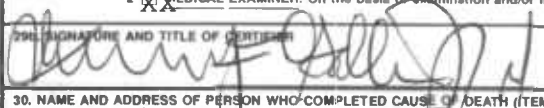

95-7083-510

B.K.S

95 36264

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>VIRGINA BRICE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |                                           | 2. DATE OF DEATH<br>MONTH NOV. DAY 22, YEAR 1995                                                                                                                                                    |  | 3. TIME OF DEATH<br>1205 P M                                                                        |                                                                                                                                                        |
| 4. SOCIAL SECURITY NUMBER<br>214-46-7560                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   | 6. AGE (In yrs. last birthday)<br>48 YRS. | 7. DATE OF BIRTH<br>MONTH 11 DAY 14 YEAR 47                                                                                                                                                         |  | 8. BIRTHPLACE (State or Foreign Country)<br>ALABAMA                                                 |                                                                                                                                                        |
| 9a. FACILITY NAME (If not institution, give street and number)<br>UNION MEMORIAL HOSPITAL E.R.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY                                                                                                                                               |  | 9c. COUNTY OF DEATH<br>BALTO. CITY                                                                  |                                                                                                                                                        |
| 10a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br>BALTO. CITY                                                                                                                       |                                           | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE                                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                                        |
| 10e. STREET AND NUMBER<br>1506 SHADYSIDE ROAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |                                           | 10f. ZIP CODE<br>21218                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                             |                                                                                                                                                        |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>AFR. AMERICAN                         |                                                                                                                                                        |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>NURSE'S AID                     |                                           | 16b. KIND OF BUSINESS/INDUSTRY<br>HOSPITAL                                                                                                                                                          |  |                                                                                                     |                                                                                                                                                        |
| 17. FATHER'S NAME (First, Middle, Last)<br>WILLIAM A. MCINTYREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>JOHNIE MAE WORTHY                                                                                                                              |  |                                                                                                     |                                                                                                                                                        |
| 19a. INFORMANT'S NAME (Type/Print)<br>REGINALD MCINTYREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1506 SHADYSIDE ROAD BALTO. MD 21218                                                                |  |                                                                                                     |                                                                                                                                                        |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>WESTERN STAR CEM. 11/30/95                                    |                                           | 20c. LOCATION — City or Town, State<br>CATONSVILLE MD                                                                                                                                               |  |                                                                                                     |                                                                                                                                                        |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |                                           | 22. NAME AND ADDRESS OF FACILITY<br>ESTEP BROTHERS FUNERAL HOME P.A.<br>1300 EUTAW PLACE BALTO. MD 21217                                                                                            |  |                                                                                                     |                                                                                                                                                        |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     | Approximate interval between Onset and Death                                                                                                           |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                              |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XX YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                              |  | 26. DATE OF INJURY (Month, Day, Year)                                                                                                            |                                           | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                           |                                           | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                   |  | 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |                                                                                                                                                        |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                       |  |                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |                                           | 29c. LICENSE NUMBER<br>O.C.M.E                                                                                                                                                                      |  | 29d. DATE SIGNED (Month, Day, Year)<br>NOV. 23, 1995                                                |                                                                                                                                                        |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARIO F. GOLTZ JR. MD 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |                                           | 32. REGISTRAR'S SIGNATURE<br>                                                                                    |  |                                                                                                     |                                                                                                                                                        |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

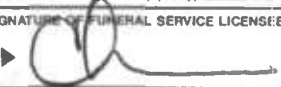

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-730 12/13/95 t.t

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BOBBY BURRIS JR.</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>26</b> YEAR <b>1995</b>                                                                                                                                                                                                                           |  | 3. TIME OF DEATH<br><b>02:31 A M</b>                                                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>28</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JAN. 30, 1967</b>                                                                                                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>26 SOUTH EXETER APT. 11G</b>                                                                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                        |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                      |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>605 SCOTT STREET</b>                                                                                                                              |  |
| 10f. ZIP CODE<br><b>21230</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                                                                                                                                                                                                                                   |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                                                                                                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th GRADE</b><br>College (1-4 or 5+) <b>LABORER</b>                                                                                                                                                                                                                                                                        |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABORER</b>                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FOOD SERVICE</b>                                                                                                                          |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>BOBBY BURRIS SR.</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BARBARA JEAN JONES</b>                                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>THELMA GILL &amp; MARY BURRIS</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1711 W. MOSHER STREET, BALTIMORE, MARYLAND 21217</b>                                                                                                                                       |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY 12-4-95</b>                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>                                                                                                              |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.<br/>1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</b>                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>NARCOTIC INTOXICATION</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input checked="" type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined                                                                                                                                        |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>FOUND 11/26/95</b>                                                                                                                                                                                                                                |  | 28b. TIME OF INJURY<br><b>UNKNOWN</b>                                                                                                                                          |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>UNKNOWN</b>                                                                                                                                                                                                                                            |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                            |  | 29b. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                         |  | 29c. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 26 1995</b>                                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HALESON B. WARRUM 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                   |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                               |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36266

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CALVIN CANNON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 23, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>9:10 A M</b>                                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-52-9261</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                      |  | 6. AGE (In yrs. last birthday)<br><b>44</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jun. 24, 1951</b>                                                                                            |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Seton Hill Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                      |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><b>909 N. Collington Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                     |  | 10f. ZIP CODE<br><b>21205</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                         |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                    |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12th</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>                                                                                                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>various trades</b>                                                                                                                                             |  |                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Albert Cannon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Dorothy Terry</b>                                                                                                                           |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Evon Cannon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1537 N. Milton Avenue/Baltimore, MD 21213</b>                                                   |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>                                                                                                                                                                         |  | DATE<br><b>11-29</b>                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State<br><b>Lansdowne, MD</b>                                                                                            |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Shirley K. Jones</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                     |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March Funeral Home East</b><br><b>1101 E. North Avenue/Baltimore, MD 21202</b>                                                                               |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACQUIRED IMMUNE DEFICIENCY SYNDROME</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                     |  | Approximate Interval Between Onset and Death                                                                                                           |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                      |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br><b>D29071</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-29-95</b>                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>R. KRISHNAN, MD 824 N. EUTAW ST #305 BALTIMORE MD 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                     |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36267

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                    |                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Velma Larez Cooper                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                 |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov 26, 1995                                                                                                                                                                                                                                                                                                                                                                               |                                                    | 3. TIME OF DEATH<br>11:40 P. M.                                                                                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br>235-48-7392                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 6. AGE (In yrs. last birthday)<br>78 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 27, 1917                                                                                                                                                                                                                                                                                                                                                                           | 8. BIRTHPLACE (State or Foreign Country)<br>W. VA. |                                                                                                                                                        |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br>Elder Care Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                 |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Sykesville                                                                                                                                                                                                                                                                                                                                                                                |                                                    | 9c. COUNTY OF DEATH<br>Carroll                                                                                                                         |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                    |                                                                                                                                                        |  |
| 10a. STATE<br>Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br>Frederick                                                                                                                                                                                                                                                                        |                                           | 10c. CITY, TOWN OR LOCATION<br>Frederick                                                                                                                                                                                                                                                                                                                                                                                         |                                                    | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br>5603 McDonald Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                 |                                           | 10f. ZIP CODE<br>21701                                                                                                                                                                                                                                                                                                                                                                                                           |                                                    | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |                                                    | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                                                                       |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 15b. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Laborer                                                                                                                                                                        |                                           | 16b. KIND OF BUSINESS/INDUSTRY<br>Fairchild Corp                                                                                                                                                                                                                                                                                                                                                                                 |                                                    |                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Glenn Teter, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                 |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Florence Kisamore                                                                                                                                                                                                                                                                                                                                                           |                                                    |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Beulah Powell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                 |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>515 Central St. Elkins, W.VA 26241                                                                                                                                                                                                                                                                                              |                                                    |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Elkins Memorial Gardens                                                                                                                                                                                      |                                           | DATE<br>11/29                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                    | 20c. LOCATION — City or Town, State<br>Elkins, W. Va                                                                                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Phillips Stacks</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                 |                                           | 22. NAME AND ADDRESS OF FACILITY<br>Sterling Ashton Funeral Home<br>736 Edmondson Avenue, Balto, Md. 21228                                                                                                                                                                                                                                                                                                                       |                                                    |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial Infarction</i><br>Due to (OR AS A CONSEQUENCE OF):<br>b. <i>Atherosclerotic Cardiovascular Disease</i><br>Due to (OR AS A CONSEQUENCE OF):<br>c.<br>Due to (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                    |                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Sepsis</i><br><i>Hypo Thyroidism</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                    |                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |                                                    | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                          |                                           | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                            |                                                    | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                 |                                           | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |                                                    |                                                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                 |                                           | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                    |                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert Ammeling MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                 |                                           | 29c. LICENSE NUMBER<br>D 25234                                                                                                                                                                                                                                                                                                                                                                                                   |                                                    | 29d. DATE SIGNED (Month, Day, Year)<br>11/27/95                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ROBERT AMMELING MD 516 N. ROWLING RD SUITE 205 OAKVILLE, MD 21228                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                    |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 3 0 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                 |                                           | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew R... ..</i>                                                                                                                                                                                                                                                                                                                                                                          |                                                    |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36268

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

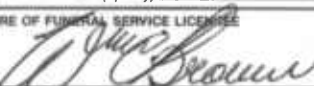


|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                        |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RUTH JOSEPHINE CROWDER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>28</b> YEAR <b>1995</b>                                                                                                                                  |  | 3. TIME OF DEATH<br><b>12:45 A M</b>                                                                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>231-42-7318</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/6/34</b>                                                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3114 Fairview Road (res.)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Woodmoor</b>                                                                                                                                              |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                        |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                            |  | 10c. CITY, TOWN OR LOCATION<br><b>Woodmoor</b>                                                                                                                                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                    |  |
| 10e. STREET AND NUMBER<br><b>3114 Fairview Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21207</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                            |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>5+</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>                                                                                                                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>School System</b>                                                                                                                                              |  |                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph S. Johnson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rebecca Helen Boykin</b>                                                                                                                    |  |                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Bonnik Finch</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18 Morrow Court, Randallstown, MD 21133</b>                                                     |  |                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet. Cem 12/4</b>                                                                                                                                                                                    |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, MD</b>                                                                                                                                      |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE 21207</b> |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                        |  |
| 23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Samuel Zyglidopoulos M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>035606</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/29/95</b>                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SAMUEL ZYGLIDOPULOS M.D. 21 CROSSROADS DRIVE OWINGS HILLS, MD. 21117</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                        |  |
| 31. DATE FILED<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Shuster-Randall</i>                                                                                                                                           |  |                                                                                                                        |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>RONALD D. CHISLEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 25, 1995                                                                                                                                         |  | 3. TIME OF DEATH<br>12:20 PM                                                                    |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br>214-86-0433                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br>28 YRS.                                                                                                                                                       |  | 7. DATE OF BIRTH (Month, Day, Year)<br>01 08 67                                                 |                                                                                                 | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                      |  |                                                                                                                                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>UNIVERSITY HOSPITAL (STU)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE                                                                                                                                                |  |                                                                                                 | 9c. COUNTY OF DEATH<br>City                                                                     |                                                                                                           |  |                                                                                                                                                        |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br>Anne Arundel Co.                                                                                                                                                                                                                                                                     |  | 10c. CITY, TOWN OR LOCATION<br>Severn                                                                                                                                                           |  |                                                                                                 | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                           |  |                                                                                                                                                        |  |
| 10e. STREET AND NUMBER<br>1423 Dorsey Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                     |  | 10f. ZIP CODE<br>21144                                                                                                                                                                          |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                         |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |                                                                                                 | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                |                                                                                                           |  |                                                                                                                                                        |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Carpenter                                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Construction                                                                                                                                                  |  |                                                                                                 |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Gardon Chisley                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Betty Mundell                                                                                                                              |  |                                                                                                 |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Betty Edmond                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7610 Delmore Road, Severn, Maryland 21144                                                      |  |                                                                                                 |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Pilgram Church Cemetery 11/30 Hanover, Maryland                                                                                                                                                              |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  | 20d. DATE                                                                                       |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                     |  | 22. NAME AND ADDRESS OF FACILITY<br>William C. Brown Community Funeral Home<br>1206 W. North Ave, Baltimore, Maryland 21217                                                                     |  |                                                                                                 |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND TO ABDOMEN<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                 | Approximate interval between Onset and Death                                                              |  |                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY (Month, Day, Year)<br>11 25 95                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>0412AM                                                                                                                                                                   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                 | 28d. DESCRIBE HOW INJURY OCCURRED<br>GUNSHOT BY POLICE                                                    |  |                                                                                                                                                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>GARDENS SECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>1400 W RD ANN ARUNDEL MD                                                                                                                                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br>O.C.M.E.                                                                                                                                                                 |  | 29d. DATE SIGNED (Month, Day, Year)<br>NOVEMBER 26, 1995                                        |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARYANN A. KORCHAK 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                    |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                 |                                                                                                           |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36270

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MADGE CHAMBERS</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>25</b> YEAR <b>95</b>                                                                                                                                                  |  | 3. TIME OF DEATH<br><b>5:30 A M</b>                                                                               |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-22-7052</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <b>2</b> <input type="checkbox"/> F                                                                                                                                                                                                                                                                                   | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>SEPT. 1, 1906</b>                                                                                                                                                       |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>CALVERT COUNTY</b>                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MERCY HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                                      |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                 |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                           |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>                                                                                                                                                              |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2534 TERRA FIRMA ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  | 10f. ZIP CODE<br><b>21225</b>                                                                                                                                                                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                                                      |  |
| 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                      |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                                        |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                  |  | College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                         |                                                  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>RETAILER</b>                                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>COSMETIC COMPANY</b>                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES HOLLAND</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LILLIAN GREEN</b>                                                                                                                                         |  |                                                                                                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>FLORENCE WILLS</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>205 SCOTT AVENUE, GLEN BURNIE, MD. 21060</b>                                                                  |  |                                                                                                                   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. AUBURN CEMETERY</b>                                                                                                                                                                                                                                                       |                                                  | DATE<br><b>11-29-95</b>                                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.<br/>1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</b>                                                                                 |  |                                                                                                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Uterine Cancer</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO                                                         |  |                                                                                                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                              |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO                |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                         |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  | 29c. LICENSE NUMBER<br><b>D40480</b>                                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/27/95</b>                                                            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FERNANDO J. FERRO, MD<br/>5810 BELAIR RD.<br/>BALTO., MD 21206</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                                   |  |                                                                                                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                     |                                                  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                     |  |                                                                                                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

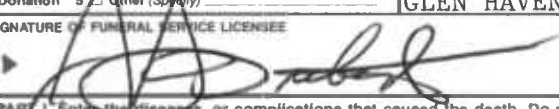
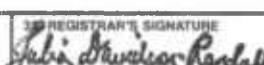
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36271

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERTA B. DEHUFF</b> Roberta Betty DeHuff                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 24 1995</b>                                                                                                                                       |  | 3. TIME OF DEATH<br><b>3:00 A.M.</b>                                                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>195-16-5559</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09-23-1916</b>                                                                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PENNSYLVANIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b>                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>GLEN BURNIE</b>                                                                                |  |
| 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                       |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>                                                                                                       |  |
| 10c. CITY, TOWN OR LOCATION<br><b>GLEN BURNIE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>316 I MOUNTAIN/RIDGE COURT</b>                                                                              |  |
| 10f. ZIP CODE<br><b>21061</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                      |  |                                                                                                                                          |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (14 or 5+) <b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>POLICE OFFICER</b>                                                                                                                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BALTIMORE CITY POLICE DEPARTMENT</b>                                                                                                                           |  |                                                                                                                                          |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HARRY E. MCGONIGAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>IONA L. BURRDICK</b>                                                                                                                        |  |                                                                                                                                          |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>SANDRA M. DeHUFF</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>316 I MOUNTAIN/RIDGE COURT, GLEN BURNIE, MD. 21061</b>                                          |  |                                                                                                                                          |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN MEMORIAL PARK</b>                                                                                                                                                                                         |  | 20c. LOCATION — City or Town, State<br><b>12/1/1995 GLEN BURNIE, MD.</b>                                                                                                                            |  | 20d. LOCATION — City or Town, State<br><b>GLEN BURNIE, MD.</b>                                                                           |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>                                                                                    |  |                                                                                                                                          |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia &amp; bil. pleural effusions</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Colon cancer</b> |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | Approximate interval Between Onset and Death                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Failure</b><br><b>Cardiomyopathy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                                                          |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                                                          |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                                                          |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                          |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>I. LIVAS, HOUSE OFFICER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>047258</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-29-95</b>                                                                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLEN BURNIE, MD. 21061</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                          |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                    |  |                                                                                                                                          |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36272

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNIE PRAKE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>23</b> YEAR <b>1995</b>                                                                                                                             |  | 3. TIME OF DEATH<br><b>1120 AM</b>                                                                                                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-18-1631</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/1/1916</b>                                                                                                                        |  |
| 8. BIRTHPLACE (State or Foreign)<br><b>Wilmington North Carolina</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Mercy Hospital</b>                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto.</b>                                                                                                                           |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>MD</b>                                                                                                                                                                         |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                      |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>5314 Peerless Avenue</b>                                                                                                                          |  |
| 10f. ZIP CODE<br><b>21207</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                     |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                                                                                                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Domestic Worker</b>                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Residential Housekeeping</b>                                                                                                              |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Samuel Parham</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Pattie Townes</b>                                                                                                                       |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Pattie Owens</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5314 Peerless Ave. Balto. Md 21207</b>                                                      |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation — 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery 11/29/95 Balto. Md</b>                                                                |  | 20c. LOCATION — City or Town, State                                                                                                                                            |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leroy O. Dyett &amp; Son Funeral Home<br/>4600 Liberty Hgts Ave. Balto. Md</b>                                                                           |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aspiration Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Dementia with gastrostomy tube dependence years</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>7 days</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>congestive heart failure</b><br><b>hypertension</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>N/A</b>                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                    |  |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)<br><b>N/A</b>                                                                                                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>David Badawl, MD</b><br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>David Badawl, MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER <b>P09133</b> 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 23 1995</b>                                                                                                     |  |                                                                                                                                                                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DAVID BADAWL, MD Mercy Hospital, Baltimore MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 20 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John William Randall</i>                                                                                                                                        |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36273

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                           |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES DAY SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/19/95</b>                                                                                                                                               |  | 3. TIME OF DEATH<br><b>6:45 P M</b>                                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218 05 5765</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input type="checkbox"/> F<br><b>1</b>                                                                                                                                                                                                                            |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/26/07</b>                                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>(HOME) 914 N. CARROLTON AVE.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>BALTO.</b>                                                                      |  |
| 10a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>BALTO. CITY</b>                                                                                                                                                                   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                           |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br><b>1</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 10e. STREET AND NUMBER<br><b>914 N. CARROLTON AVE.</b>                                                                                                                                              |  |                                                                                                           |  |
| 10f. ZIP CODE<br><b>21217</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                         |  |                                                                                                           |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>AFR. AMERICAN</b>                        |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>UNKNOWN</b>                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>UNKNOWN</b>                                                                                                                                                    |  |                                                                                                           |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>                                                                                                                                 |  |                                                                                                           |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JAMES DAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>914 N. CARROLTON AVE, BALTO, MD. 21217</b>                                                      |  |                                                                                                           |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. ZION CEM. 11/24/95</b>                                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br><b>LANSLOWNE, MD.</b>                                                                                                                                        |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Cal A. Doty</i>                                           |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>ESTEP BROTHERS FUNERAL HOME P.A.<br/>1300 EUTAW PL. BALTIMORE, MD. 21217</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                           |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PROSTATIC CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>DEMENTIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | Approximate Interval Between Onset and Death<br><b>3 YEARS</b><br><b>5 YEARS</b>                          |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                           |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                           |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                           |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                           |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D37233</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 29, 95</b>                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOSEPH HUBAYKAH 821 N. EUTAW STREET SUITE 308</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                           |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Radell</i><br><b>BALTO-MD 21201</b>                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                           |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

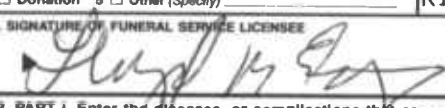





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Hattie Duncan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>27</b> YEAR <b>1995</b> 12:48A                                                                                                                 |                                                    | 3. TIME OF DEATH<br><b>12:48A</b>                                                           |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>251-44-9824</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>76</b> DAYS <b>76</b>                                                                                                                                              | IF UNDER 24 HRS.<br>HOURS <b>76</b> MIN. <b>76</b> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>11 26 1919</b>                                 |                                                                                                       |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Maryland General Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                                                                                                                                    |                                                    | 9c. COUNTY OF DEATH<br><b>Baltimore City</b>                                                |                                                                                                       |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                                  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                   |                                                    | 10b. COUNTY<br><b>BALTIMORE</b>                                                             |                                                                                                       |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |                                                  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                 |                                                    |                                                                                             |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>501-DOLPHIN STREET APT. 1210</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                  | 10f. ZIP CODE<br><b>21201</b>                                                                                                                                                                   |                                                    | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                 |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                                    | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEKEEPER</b>                                                                                                                                                            |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOTEL</b>                                                                                                                                                  |                                                    |                                                                                             |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAKE JORDAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LOTTIE WHITE JORDAN</b>                                                                                                                 |                                                    |                                                                                             |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARILYNN L. DUNCAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2517 HURON STREET BALTIMORE, MARYLAND 21230</b>                                             |                                                    |                                                                                             |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, church, or other place)<br><b>KING MEM. PARK 12/1/95</b>                                                                                                                                                                                 |                                                  | DATE<br><b>12/1/95</b>                                                                                                                                                                          |                                                    | 20c. LOCATION — City or Town, State<br><b>RANDALLSTOWN, MARYLAND</b>                        |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>ESTEP BROTHERS FUNERAL HOME PA.<br/>1300 EUTAW PLACE BALTIMORE, MARYLAND 21217</b>                                                                       |                                                    |                                                                                             |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             | Approximate Interval Between Onset and Death<br><b>2 days</b>                                         |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Possible Myocardial Infarction, Chronic Renal Failure, Atrial Fibrillation, hypertension</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |                                                    | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |                                                  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |                                                    |                                                                                             |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Shawar RESIDENT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |                                                  | 29c. LICENSE NUMBER<br><b>89234</b>                                                                                                                                                             |                                                    | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-27-95</b>                                      |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SHAKIR SARWAR 827 LINDEN AVE. BALTO. MD 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 20 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                               |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36275

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RODNEY BARNETT DIXON</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                        |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 23 1995</b>                                                                                                                                           |  | 3. TIME OF DEATH<br><b>6:05A M</b>                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-76-1710</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                                         |  | 6. AGE (In yrs. last birthday)<br><b>36</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3-2-1959</b>                                         |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MERCY HOSPICE</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                           |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                        |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4408 FREDERICK AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                        |  | 10f. ZIP CODE<br><b>21229</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                       |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                       |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HANDYMAN</b>                                                                                                                                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>UNKNOWN</b>                                                                                                                                                    |  |                                                                                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES DIXON</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                        |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HATTIE INGRAMS</b>                                                                                                                          |  |                                                                                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>HATTIE INGRAMS</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                        |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4408 FREDERICK AVENUE BALTIMORE, MARYLAND 21229</b>                                             |  |                                                                                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of place)<br><b>ARBUTUS MEM. PARK 11/29/95</b>                                                                                                                                                                                                                                |  | DATE<br><b>11/29/95</b>                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br><b>ARBUTUS, MARYLAND</b>                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Carl G. [Signature]</i>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                        |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ESTEP BROTHERS FUNERAL HOME PA.<br/>1300 EUTAW PLACE BALTIMORE, MARYLAND 21217</b>                                                                           |  |                                                                                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ACQUIRED IMMUNE DEFICIENCY SYNDROME</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                 |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                      |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                      |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Kendall R. Faulkner</i>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                        |  | 29c. LICENSE NUMBER<br><b>D25643</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/24/95</b>                                            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KR FAULKNER / 2300 Dulany Valley Rd / Balto 21204</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                        |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                     |  |                                                                                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36276

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>BARBARA D. EDWARDS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                               |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 26, 1995                                                                                                                                             |  | 3. TIME OF DEATH<br>0855 AM                                                          |                                                                                                                                                        |
| 4. SOCIAL SECURITY NUMBER<br>217-20-5636                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                |  | 6. AGE (In yrs. last birthday)<br>74 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>DEC. 21, 1920                                 |                                                                                                                                                        |
| 9a. FACILITY NAME (If not institution, give street and number)<br>UNION MEMORIAL HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                               |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY                                                                                                                                               |  | 9c. COUNTY OF DEATH<br>n/a                                                           |                                                                                                                                                        |
| 10a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                               |  | 10b. COUNTY<br>n/a                                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE                                             |                                                                                                                                                        |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |
| 10e. STREET AND NUMBER<br>2612 VIOLET AE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                               |  | 10f. ZIP CODE<br>21215                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES                                       |                                                                                                                                                        |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                     |                                                                                                                                                        |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 th College (14 or 5+) -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                               |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>COOK                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>DOMESTIC -various                                  |                                                                                                                                                        |
| 17. FATHER'S NAME (First, Middle, Last)<br>WARD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                               |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MAGGIE JOHNSON                                                                                                                                 |  |                                                                                      |                                                                                                                                                        |
| 19a. INFORMANT'S NAME (Type/Print)<br>IRENE KESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                               |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5110 BALTIMORE NATIONAL PIKE, apt. 207, # 29                                                       |  |                                                                                      |                                                                                                                                                        |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                               |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>KING MEMORIAL PARK 12-2                                                                                                                                                                                                                    |  | 20c. LOCATION — City or Town, State<br>RANDALLSTOWN, MD                                                                                                                                             |  |                                                                                      |                                                                                                                                                        |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sharon Mahoney-Davis</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                               |  | 22. NAME AND ADDRESS OF FACILITY<br>WM. C. MARCHH . 1101 E. NORTH AVENUE                                                                                                                            |  |                                                                                      |                                                                                                                                                        |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. UROSEPSIS<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Recto vaginal Fistula<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  |                                                                                      | Approximate Interval Between Onset and Death<br>one week<br>2 months                                                                                   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DEMENTIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  |                                                                                      | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  |                                                                                      | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) EXTENDED CARE UNIT |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                        |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                                        |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                               |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                      |                                                                                                                                                        |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Manuel V Ramos MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                               |  | 29c. LICENSE NUMBER<br>D38950                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/26/95                                      |                                                                                                                                                        |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MANUEL RAMOS, MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                               |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>                                                                                                                                                     |  |                                                                                      |                                                                                                                                                        |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

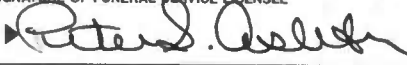

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36277

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Myra Evans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 22 1995                                                                                                                                              |  |                                                                                      |  | 3. TIME OF DEATH<br>4:51 P M                                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br>212-07-6526                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>90 YRS.                                                                                                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                       |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                                                                                         |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br>4-11-05                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                                                                                                                |  |                                                                                      |  |                                                                                                                                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Riverview Nursing Centre, Inc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Essex                                                                                                                                                        |  |                                                                                      |  | 9c. COUNTY OF DEATH<br>Baltimore                                                                                                                       |  |
| 10a. STATE<br>Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                   |  | 10c. CITY, TOWN OR LOCATION<br>Dundalk                                                                                                                                                              |  |                                                                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br>3405 Courtway                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21222                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                              |  |                                                                                                                                                        |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |                                                                                                                                                        |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10 yrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | College (1-4 or 5+)<br>16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home                                                                                                                                                          |  |                                                                                      |  |                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Lawrence May                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mamie Schultz                                                                                                                                  |  |                                                                                      |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Dorothy Eberling                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3405 Courtway, Dundalk, Md. 21222                                                                  |  |                                                                                      |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Chesapeake Crematory 11-24-95 Beltsville, Md.                                                                                                                                                                           |  | DATE                                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State                                                  |  |                                                                                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>Bradley-Ashton Funeral Home, Inc.<br>2134 Willow Spring Rd., Balto., Md. 21222                                                                                  |  |                                                                                      |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Stroke</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Hypertension</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | Approximate Interval Between Onset and Death<br>10 days<br>many years                                                                                  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Diabetes mellitus, Atrial Fibrillation</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                      |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                      |  |                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                            |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>N. Deshpande M.D.                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
| 29c. LICENSE NUMBER<br>D46082                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/24/95                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Neeta Deshpande, MD Franklin Square Hospital Center Baltimore, Md. 21237                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 3 0 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Linwood V. Edwards</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>27</b> , YEAR <b>1995</b>                                                                                                                      |  | 3. TIME OF DEATH<br><b>8:00 A M</b>                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-78-7467</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>33</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>MONTH <b>October</b> DAY <b>15</b> , YEAR <b>1962</b>                       |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>BAYVIEW HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>n/a</b>                                                               |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>n/a</b>                                                                                                                                                                                                                                                                   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>230 DOUGLAS COURT</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><b>21230</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                           |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify <b>BLACK</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9 th</b> College (1-4 or 5+) <b>-</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>ROOFER</b>                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>ROOFING COMPANY</b>                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LYNWOOD EDWARDS</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BEULAH STOKES</b>                                                                                                                       |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>BEULAH WRIGHT</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3448 BELAIR ROAD, BALTIMORE, MD 21213</b>                                                   |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>VOSHELL MEMORIAL GARDENS 12-1 DUNDALK, MD</b>                                                                                                                                                         |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  | 20d. DATE                                                                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John A. Underwood</i>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM. C. MARCH FH. 1101 E. NORTH AVENUE</b>                                                                                                                |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| b. <b>Chronic Renal Failure x 2 years</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Paraplegia</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                         |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James A. Underwood MD</i>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>M6175</b>                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 27, 1995</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JAMES A. UNDERWOOD, MD, 1 JOHN HOPKINS HOSPITAL, BALTIMORE, MD</b>                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b> <i>John A. Underwood</i>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36279

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REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                           |  |                                                                                                                                                 |  |                                                                            |  |                                                                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PAULINE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>27</b> YEAR <b>1995</b>                                                                        |  |                                                                            |  | 3. TIME OF DEATH<br><b>12:25 P M</b>                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>141-12-6479</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><b>1 M 2 F</b>                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS.                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 22, 1901</b>                |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>New Jersey</b>                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Laurel Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Laurel</b>                                                                                            |  |                                                                            |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b>                                                    |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                          |  | 10c. CITY, TOWN OR LOCATION<br><b>Bethesda</b>                                                                                                  |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>                                                    |  |
| 10e. STREET AND NUMBER<br><b>8210 Beachtree Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           |  | 10f. ZIP CODE<br><b>20817</b>                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                             |  |                                                                                                  |  |
| 11. MARITAL STATUS<br><b>3 X Widowed 4 Divorced</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |                                                                                                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own home</b>                          |  |                                                                                                  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Morris Kaplan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Fanny (UNKNOWN)</b>                                                                     |  |                                                                            |  |                                                                                                  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Shari Gelman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8210 Beachtree Rd., Bethesda, Md. 20817</b> |  |                                                                            |  |                                                                                                  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King David Mem. Grdn 11-29-95/ Falls Church, Va</b> |  | 20c. LOCATION — City or Town, State<br><b>Va</b>                                                                                                |  |                                                                            |  |                                                                                                  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Emil P. Holland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ives-Pearson Funeral Homes<br/>Falls Church, Va 22046</b>                                                |  |                                                                            |  |                                                                                                  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Generalized Atherosclerotic Cardiovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                           |  |                                                                                                                                                 |  |                                                                            |  | Approximate Interval Between Onset and Death<br><b>years</b>                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |  |                                                                                                                                                 |  |                                                                            |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <b>YES NO X UNCERTAIN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |  |                                                                                                                                                 |  |                                                                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)</b>    |  |                                                                                                                                                 |  |                                                                            |  |                                                                                                  |  |
| 27. MANNER OF DEATH<br><b>1 X Natural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be determined</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                    |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                 |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                              |  |                                                                                                                                                 |  |                                                                            |  |                                                                                                  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>                                                                                                                                                                                                                                                    |  |                                                                                                                                           |  |                                                                                                                                                 |  |                                                                            |  |                                                                                                  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Berger MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |  | 29c. LICENSE NUMBER<br><b>D25925</b>                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 27, 1995</b>            |  |                                                                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. BERGER MD #205, 7720 Wisconsin Ave, Bethesda, Md 20814</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |  |                                                                                                                                                 |  |                                                                            |  |                                                                                                  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Anderson-Randall</i>                                                                                |  |                                                                                                                                                 |  |                                                                            |  |                                                                                                  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36280

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |                                                                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Geneva Epps</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>28</b> YEAR <b>1995</b>                                                                                                                                                                                                                     |  |                                                                                  |  | 3. TIME OF DEATH<br><b>11:14 A.M.</b>                                                                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-68-3984</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>101</b> YRS.                                                                                                                                                                                                                                            |  | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> |  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>                                                                       |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>2/7/1894</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>S.C.</b>                                                                                                                                                                                                                                      |  |                                                                                  |  |                                                                                                                                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LIBERTY MED. CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTO.</b>                                                                                                                                                                                                                                         |  |                                                                                  |  | 9c. COUNTY OF DEATH<br><b>BALTO. CITY</b>                                                                                                              |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |                                                                                                                                                        |  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>BALTO. CITY</b>                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                                                                                                              |  |                                                                                  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><b>1723 BRADDISH AVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 10f. ZIP CODE<br><b>21216</b>                                                                                                                                                                                                                                                                |  |                                                                                  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                         |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                          |  |                                                                                  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>AFR. AMERICAN</b>                                                                        |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>UNKNOWN</b>                                                                                                                                                              |  |                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>UNKNOWN</b>                                                                                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>TOBB NESBITT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>FANIA NESBITT</b>                                                                                                                                                                                                                    |  |                                                                                  |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>EVA CALDWELL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4514 OLD FREDERICK AVE. BALTO. MD 21229</b>                                                                                                                                              |  |                                                                                  |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. CALVARY CEM.</b>                                                                                                                                                                                   |  |                                                                                  |  | 20c. LOCATION — City or Town, State<br><b>GLEN BURNIE MD</b>                                                                                           |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ESTEP BROTHERS FUNERAL HOME P.A.<br/>1300 EUTAW PLACE BALTO. MD 21217</b>                                                                                                                                                                             |  |                                                                                  |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Atherosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Infected Sacral Decubitus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                  |  | Approximate Interval Between Onset and Death<br><b>Years</b>                                                                                           |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cardiovascular Accident</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                  |  |                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                       |  | 28b. TIME OF INJURY<br><b>M</b>                                                  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                            |  |                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>George E. Wicks III M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>D41365</b>                                                                                                                                                                                                                                                         |  |                                                                                  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 28, 1995</b>                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>George E. Wicks III M.D. 2600 Liberty Heights Ave 21215</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                              |  |                                                                                  |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36281

ITEM: 1. PER F.H. FILM G-729 11/30/95 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Hannah L. EPPEL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 27, 1995</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 3. TIME OF DEATH<br><b>~6:45A M</b>                                                                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213145663</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>95</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                 |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JULY 20, 1900</b>                                                                                                                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>LITHUANIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                          |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                              |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>2500 W. BELVEDERE AVE., APT. 705</b>                                                                                                                      |  |
| 10f. ZIP CODE<br><b>21215</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                                                                                                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOMEMAKER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>OWN HOME</b>                                                                                                                                                                                                                                                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SHLOMO SEGALL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DR. DAVID M. EPPEL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6706 BAYTHORNE ROAD BALTIMORE, MD 21209</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>(ANSHE EMUNAH) AITZ CHAIM- 11-28-1995 BALTIMORE, MD</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Scott M. Cuth</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Pulmonary Edema</b> ~6hrs<br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Sepsis</b> ~6hrs<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Mesenteric Ischemia</b> ~12 hrs<br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Atherosclerosis</b> >20yrs |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>NOV 27 1995</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Pearl Lubner M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 29c. LICENSE NUMBER<br><b>A52402321-PL9838</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>November 27, 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Sinai Hospital Baltimore</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>Johi Brundage-Raslett</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND AND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





**DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020**

## REG. NO.

DHMH-16 Rev 1/89

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a discussion of the results of the study. It presents the findings of the research and discusses their implications for the field of study.

4. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides a final statement on the research. The references list the sources of information used in the study.

95 36283

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GLADYS FLEMING</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>28</b> YEAR <b>1995</b>                                                                                                                                                                                                                       |  | 3. TIME OF DEATH<br><b>944 A.M.</b>                                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-12-8113</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 6, 1911</b>                                                                                                                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sinai Hospital</b>                                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                        |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                      |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>1818 W. Mosher St.</b>                                                                                                                            |  |
| 10f. ZIP CODE<br><b>21217</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                    |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  |                                                                                                                                                                                |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Afro-American</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary <input type="checkbox"/> Secondary (9-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>                                                                                    |  |                                                                                                                                                                                |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Clerk</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government</b>                                                                                                                                                                                                                                       |  |                                                                                                                                                                                |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William P. Bailey</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rose Smallwood</b>                                                                                                                                                                                                                     |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Barbara Hill</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5903 Winner Ave. Balto. Md. 21215</b>                                                                                                                                                      |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial 12/2/95 Balto. Md.</b>                                                                                                                                                                  |  |                                                                                                                                                                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Russ</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto. Md. 21216</b>                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Gastrointestinal Bleed</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Disseminated Intravascular Coagulation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Severe mitral regurgitation and moderately severe stenosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Chronic Renal Insufficiency</b><br>Approximate Interval Between Onset and Death<br><b>3 days</b><br><b>1 day</b><br><b>years.</b> |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>pulmonary hypertension</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |
| 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                    |  |                                                                                                                                                                                |  |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Anil K. Dubey MD P64-II Resident</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>AS2402321-AD9820</b>                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>November 28, 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ANIL K. DUBEY, MD SINAI Hospital of Baltimore Baltimore, Maryland.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36284

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                 |  |                                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Robert L Foxwell</i>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH <i>Nov</i> DAY <i>28</i> YEAR <i>95</i>                                                                                                                               |  | 3. TIME OF DEATH<br><i>3:00 P M</i>                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br><i>216-03-5794</i>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. AGE (In yrs. last birthday)<br><i>85</i> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Sept. 5, 1910</i>                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>St. Agnes Hospital</i>                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>                                     |  |
| 9c. COUNTY OF DEATH<br><i>N/A</i>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10a. STATE<br><i>Maryland</i>                                                                                                                                                                   |  | 10b. COUNTY<br><i>Baltimore</i>                                                             |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Halethorpe</i>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><i>5711 1st Avenue</i>                                            |  |
| 10f. ZIP CODE<br><i>21227</i>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>                                                                                                                                           |  |                                                                                             |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>white</i>                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><i>+4</i>                                                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Engineer</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Western Electric</i>                                                                                                                                       |  |                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>John Leven Foxwell</i>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Susan Hindman</i>                                                                                                                       |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Edith Foxwell</i>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>5711 1st Avenue Halethorpe, Maryland 21227</i>                                              |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Loudon Park Cemetery 12/1</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br><i>Baltimore, Maryland</i>                                                                                                                               |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                             |  |
| 22. NAME AND ADDRESS OF FACILITY<br><i>Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road 21227</i>                                                                                                                                                                                                                                                                                                                         |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ventricular Fibrillation</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Myocardial Infarct</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Congestive Heart Failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate interval Between Onset and Death<br><i>1 hour</i><br><i>years ago</i><br><i>years</i> |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Diabetes</i>                                                                                                                                                                                                                                                                                    |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |                                                                                             |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28b. TIME OF INJURY<br><i>M</i>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 29c. LICENSE NUMBER<br><i>P07540</i>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>Nov 28 1995</i>                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Jeffrey Sullivan 900 Caten Avenue Baltimore MD</i>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 30 1995</i>                                                                                                                                                                                                                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                 |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Sept. 5, 1910 Maryland

85

x

216-03-2794

N/A

Baltimore

St. Agnes Hospital

x

Halethorpe

Maryland Baltimore

United States

21227 b

2711 1st Avenue

x

x

x

white

FilmG, 730, item #1, 12/1/95, cyw, per f.h.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                      |  |                                                                                                                                                     |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROY JAMES GALE</b><br><del>ROY GALE</del> <b>Roy James Gales</b>                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 26 95</b>                                                                                                |  | 3. TIME OF DEATH<br><b>0436</b> M                                                                                                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-16-7040</b>                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><b>1</b> M <b>2</b> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.                                                                                                     |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07/20/10</b>                                                                                              |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>MARYLAND GENERAL HOSPITAL</b>                                                   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                             |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10a. STATE<br><b>MD</b>                                                                                                                              |  | 10b. COUNTY<br><b>NA</b>                                                                                                                            |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO                                                                                                 |  | 10e. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                         |  |
| 11. MARITAL STATUS<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>NA</b>                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Auto Mechanic</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Automobile Dealer</b>                                                                                           |  |                                                                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SAMUEL GALE</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CARRIE</b>                                                                                   |  |                                                                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Julia Gale</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>701 N. Arlington Ave. #606 Balto. Md 21217</b>   |  |                                                                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)                                                                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)<br><b>King Henry Park 12/1/95</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br><b>Randallstown, Md</b>                                                                                       |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Phyllis B. Harris</b>                                                                               |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>MARCH FUNERAL HOME - WEST 4300 Wabash Ave. Balto Md 21215</b>                                                                                                                                                                                                                                                                              |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CHF (Congestive Heart Failure)</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. Renal parenchymal disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Hepatoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |                                                                                                                                                      |  |                                                                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                      |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO                                                                                          |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                      |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA<br>OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                      |  |                                                                                                                                                     |  |
| 27. MANNER OF DEATH<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide                                                                                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                      |  | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO                                                                                                    |  |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                 |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                         |  |                                                                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                      |  |                                                                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>N. Kolonago MD</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br><b>89247</b>                                                                                                                  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/26/95</b>                                                                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KOLONAGO Maryland General Hospital Balto, Md. 2/20/01</b>                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                      |  |                                                                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                           |  | 32. REGISTRAR'S SIGNATURE<br><b>John M. Randall</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                      |  |                                                                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P. O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36286

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EVELYN R GEBHARDT</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>Nov</b> DAY <b>21</b> YEAR <b>1995</b>                                                                                                                             |  | 3. TIME OF DEATH<br><b>7:50 pm</b>                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-30-5924</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>62</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>October 1, 1933 Maryland</b>                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson, Maryland</b>                                                                                                                                  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                         |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>8611 Saxon Circle</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21236</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                           |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>9TH Grade</b>                                                                                                                                                                                                                                                                                                                                       |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>                                                                                                                                               |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Andrew Helfer</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bridgette J. Corcoran</b>                                                                                                               |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Henry Gebhardt</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8611 Saxon Circle Baltimore, MD 21236</b>                                                   |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Joseph's Cemetery 11/25</b>                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                               |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Schimunek Funeral Home, Inc<br/>9705 Belair Rd Baltimore MD 21236</b>                                                                                    |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  | <b>a. CARDIAC ARREST SECONDARY TO CARDIAC ARRHYTHMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. HYPOTENTION AND ACIDOSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. GANGRENE OF INTESTINE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. DEHYDRATION &amp; ANEMIA</b>            |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                                                                                                                                                 |  | <b>45 minutes</b><br><b>unknown</b><br><b>unknown</b>                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>METASTATIC SQUAMOUS CARCINOMA</b>                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D 22733</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/25/95</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SHELDON LERMAN, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE OF DEATH (Month, Day, Year)<br><b>NOV 21 1995</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                   |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



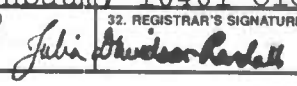
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36287

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Jennie W. Ginns</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 13, 1995</b>                                                                                                                                                                                                                                     |  | 3. TIME OF DEATH<br><b>6:10 A M</b>                                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>089-05-8212</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>APRIL 6, 1910</b>                                                                                                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Montgomery General Hospital</b>                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Olney</b>                                                                                                                            |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                               |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>2921 N. Leisure World</b>                                                                                                                         |  |
| 10f. ZIP CODE<br><b>20906</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                 |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  |                                                                                                                                                                                |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>                                                                                                                                                         |  |                                                                                                                                                                                |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>High School</b>                                                                                                                                                                                                                                           |  |                                                                                                                                                                                |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Isidore Weinfeld</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary (UNKNOWN)</b>                                                                                                                                                                                                                     |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Edward I. Ginns</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8617 Rayburn Rd., Bethesda, Md. 20817</b>                                                                                                                                                  |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Ararat Cem. 11/19/95/ Farmingdale, N.Y.</b>                                                                                                                                                          |  |                                                                                                                                                                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ives-Pearson Funeral Homes<br/>Falls Church, Va 22046</b>                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cerebrovascular Accident</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| b. <b>Anterior Myocardial Infarction</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| c. <b>Coronary Artery Disease</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| d.                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| Approximate Interval Between Onset and Death<br><b>10 days</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| Approximate Interval Between Onset and Death<br><b>2 weeks</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| Approximate Interval Between Onset and Death<br><b>Years</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Remote Cerebrovascular Accident</b>                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                |  |
| 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                    |  |                                                                                                                                                                                |  |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  |                                                                                                                                                                                |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>D27886</b>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 27, 1995</b>                                                                                                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Eric Tannenbaum, 10401 Old Georgetown Rd., #204, Bethesda, Md. 20814</b>                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 3 0 1995</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                               |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

25

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-7182-510

B.K.S

95 36288

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>SHAWN GASKINS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 27, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>8:43 A M</b>                                                                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-96-2231</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>15 YRS.</b>                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 24, 1980</b>                                                                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNIVERSITY HOSPITAL S.T.U</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>N / A</b>                                                                                                                |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10b. COUNTY<br><b>N / A</b>                                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><b>1823 Druid Hill Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21217</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                                                                                      |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                                                                         |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b><br>College (1-4 or 5+) <b>N 2A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Student</b>                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Student</b>                                                                                                                                                |  |                                                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Dorrell Gaskins</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sharon Parker</b>                                                                                                                       |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Shirley Knox</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1823 druid Hill Ave, Baltimore, Md 21217</b>                                                |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. Zion Dec. 2,</b>                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><b>baltimore, Co.</b>                                                                                                                                    |  |                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Carlton C. Douglass</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Carlton C. Douglass Funeral Service 1701 McCulloh Street Baltimore, Md 21217</b>                                                                         |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Gunshot Wound (2 to left breast and right forearm)</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11/26/95</b>                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>2:30 PM</b>                                                                                                                                                           |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject shot</b>                                                                                                                                                                                                                                       |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>1800 block Druid Hill Avenue in Baltimore City</b>                                                           |  |                                                                                                                                                    |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Theodore M. King MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>O.C.M.E</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 28, 1995</b>                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Theodore M. King 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Radell</i>                                                                                                                                          |  |                                                                                                                                                    |  |

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Alicia E. Griffin</b>                                                                                                                                                                                                                      |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>26</b> YEAR <b>1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 3. TIME OF DEATH<br><b>11:00 A.M.</b>                                                                                                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-34-3591</b>                                                                                                                                                                                                                                           |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>57</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7. DATE OF BIRTH<br>MONTH <b>July</b> DAY <b>29</b> YEAR <b>1938</b>                                                                                                                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                               |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>2921 Rockrose Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                         |  |                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                              |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                           |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10e. STREET AND NUMBER<br><b>2921 Rockrose Ave.</b>                                                                                                                                    |  |
| 10f. ZIP CODE<br><b>21215</b>                                                                                                                                                                                                                                                             |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                          |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                   |  |                                                                                |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Nurses Aide</b>                                                                                                                                                          |  |                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George Smith</b>                                                                                                                                                                                                                            |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mildred Bacon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>James Green</b>                                                                                                                                                                                                                                  |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2921 Rockrose Ave. Balto. Md. 21215</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                           |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Elizabeth</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |
| 20c. LOCATION — City or Town, State<br><b>Lansdowne, Md.</b>                                                                                                                                                                                                                              |  |                                                                                |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Russ</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph L. Russ Funeral Home</b><br><b>2222 W. North Ave. Balto. Md. 21216</b>                                                                                                                                                                      |  |                                                                                |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Esophageal Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br><b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>3 wks</b> |  |                                                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                 |  |                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                  |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                     |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11/28/95</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                           |  |                                                                                |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                         |  |                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                              |  |                                                                                |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>James Elder MD Attending</b>                                                                                                                                                                                                                  |  |                                                                                |  | 29c. LICENSE NUMBER<br><b>038993</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>11/28/95</b>                                                                                                                                                                                                                                    |  |                                                                                |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James Elder MD 2600 Liberty Hgts Baltimore MD 21215</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                   |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Shuster-Karall</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





ITEM: 16b, PER F.H. FILM G-729 11/30/95 t.t

ITEM: 3. PER FACILITY FILM G-729 11/29/95 t.t

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                    |  |                                                                                                                                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN IRVING GRAY</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 27, 1995</b>                                                                                                                                                                                                     |  | 3. TIME OF DEATH<br><b>5:45 A M</b>                                                                                                                          |  |
| 4. SOCIAL SECURITY NUMBER<br><b>056-07-4651</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 6. AGE (In yrs. last birthday)<br><b>90</b> YRS.                                                                                                                                                                                                                   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>August 26, 1905</b>                                                                                                |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>G.B.M.C.</b>                                                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                                                                                         |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                      |  |                                                                                                                                                              |  |
| 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 10c. CITY, TOWN OR LOCATION<br><b>Parkville</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                    |  | 10e. STREET AND NUMBER<br><b>9506 Ridgely Ave.</b>                                                                                                           |  |
| 10f. ZIP CODE<br><b>21234</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                     |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b> |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs</b><br>College (1-4 or 5+) <b>Asst Director</b>                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Asst Director</b>                           |  |
| 16b. KIND OF BUSINESS/INDUSTRY<br><b>BALTIMORE CITY RECREATION &amp; PARKS</b>                                                                                                                                                                                                                                                                                                                                               |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>IRVING BENNETT GRAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ADA BROOKS</b>                                                                                                                                                                                             |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Gail High</b>                                                                                                       |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9506 Ridgely Ave. Baltimore, Md. 21234</b>                                                                                                                                                                                                                                                                               |  | 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Providence U.M. 11-29 Towson, Md.</b>                                                                                                                                        |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John E. Salan</i>                                                                                            |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>                                                                                                                                                                                                                                                                                                                |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Aspiration pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Cerebrovascular disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  | Approximate interval between Onset and Death<br><b>3 days</b><br><b>5 years</b>                                                                                                                                                                                    |  |                                                                                                                                                              |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                 |  |                                                                                                                                                              |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                        |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  |                                                                                                                                                              |  |
| 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                       |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                        |  |                                                                                                                                                              |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                       |  |                                                                                                                                                              |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John E. Salan</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 29c. LICENSE NUMBER<br><b>D32783</b>                                                                                                                                                                                                                               |  |                                                                                                                                                              |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>11/27/95</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Joseph Adams 7401 Osler Dr. Towson, Md. Suite 206</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                            |  |                                                                                                                                                              |  |
| 32. REGISTRAR'S SIGNATURE<br><i>John E. Salan</i>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                    |  |                                                                                                                                                              |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36291

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William Thomas Grieves, II</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>23</b> YEAR <b>1995</b>                                                                                                                      |  | 3. TIME OF DEATH<br><b>4:30 p<sup>m</sup></b>                                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-28-7124</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>65</b> YRS.                                                                                                                                              |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 20, 1930</b>                                     |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>3633 Rockberry Road</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Parkville</b>                                                                                                                                       |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                         |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Parkville</b>                                                                                                                                               |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3633 Rockberry Road</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21234</b>                                                                                                                                                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                           |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                               |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Audio Visual</b>                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government Social Security Administration</b>                                                                                                       |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Olin Grieves</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Martha Jane Phifer</b>                                                                                                                |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. William T. Grieves, III</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10627 Anglohill Road Cockeysville, Md. 21030</b>                                          |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery 11/27/95</b>                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                             |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Mark T. Zavovna</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214</b>                                                                                       |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary Thrombosis</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| a. <b>Coronary Artery Disease</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| b. <b>Hypertension</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> NO                                                                                                                                          |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)                                                                                                        |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Manuel Cavallero</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D28177</b>                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/30/95</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>6801 BELAIR RD BALTIMORE MD. 21206</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 31. DATE OF DEATH<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>Jane [Signature]</b>                                                                                                                                          |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Emma K. Goeller                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 28 1995                                                                                                                                                |  | 3. TIME OF DEATH<br>1:05 A M                                                         |                                                                                                           |
| 4. SOCIAL SECURITY NUMBER<br>218-14-6086                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>90 YRS.                                                                                                                                                         |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Nov. 16, 1905 Maryland                     |                                                                                                           |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Charlestown Nursing Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Catonsville                                                                                                                                                |  | 9c. COUNTY OF DEATH<br>Baltimore                                                     |                                                                                                           |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br>Talbot                                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br>Easton                                                |                                                                                                           |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                                                           |
| 10e. STREET AND NUMBER<br>33520 Tuckahoe River Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21601                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                       |                                                                                                           |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                  |                                                                                                           |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>tailor                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br>garment                                            |                                                                                                           |
| 17. FATHER'S NAME (First, Middle, Last)<br>Francis Dvorak                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Barbara Prochaska                                                                                                                            |  |                                                                                      |                                                                                                           |
| 19a. INFORMANT'S NAME (Type/Print)<br>Emma McIntyre                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>21227<br>1822 Winans Avenue Halethorpe, Maryland                                                 |  |                                                                                      |                                                                                                           |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Meadowridge Memorial 12/1 Dorsey, Maryland                                                                                                                                                                              |  | 20c. LOCATION — City or Town, State                                                                                                                                                               |  |                                                                                      |                                                                                                           |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>Ambrose Funeral Home, Inc. Arbutus<br>1328 Sulphur Spring Road 21227                                                                                          |  |                                                                                      |                                                                                                           |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                      | Approximate Interval Between Onset and Death                                                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                      | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                                                           |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                                                           |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                                                           |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                          |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                           |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                      |  |                                                                                      |                                                                                                           |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                                                           |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>D47447                                                                                                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 28, 1995                             |                                                                                                           |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Andrew Lazaris 711 Maiden Choice Lane Catonsville, MD                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                                                           |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                   |  |                                                                                      |                                                                                                           |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

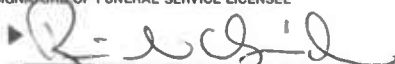
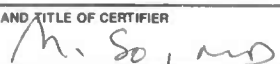

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36293

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Paula Marie Hendrickson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV. 27, 1995                                                                                                                                                 |  | 3. TIME OF DEATH<br>1:21 A. M.                                                       |                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br>336-16-3743                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             | 6. AGE (In yrs. last birthday)<br>73 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>NOV. 16, 1922                                                                                                                                             |  | 8. BIRTHPLACE (State or Foreign Country)<br>Washington, DC                           |                                                                                                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Anne Arundel Medical Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Annapolis                                                                                                                                                    |  | 9c. COUNTY OF DEATH<br>Anne Arundel                                                  |                                                                                                                                             |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |                                           | 10b. COUNTY<br>Anne Arundel                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br>Annapolis                                             |                                                                                                                                             |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                             |
| 10e. STREET AND NUMBER<br>718 Broadmoor Drive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |                                           | 10f. ZIP CODE<br>21401                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                 |                                                                                                                                             |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |                                                                                                                                             |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Benefits Coordinator                                                                                                                                                                      |                                           | 16b. KIND OF BUSINESS/INDUSTRY<br>Business                                                                                                                                                          |  |                                                                                      |                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br>Norman L. Knight                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Marie S. Yenn                                                                                                                                  |  |                                                                                      |                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br>Kristin McCabe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6913 Heidelberg Road, Lanham, Maryland 20706                                                       |  |                                                                                      |                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Baltimore-Washington Crem.<br>11/28                                                                                                                                                                                     |                                           | 20c. LOCATION — City or Town, State<br>Laurel, Maryland                                                                                                                                             |  |                                                                                      |                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |                                           | 22. NAME AND ADDRESS OF FACILITY<br>Fleck Funeral Home, Inc.<br>7601 Sandy Spring Road, Laurel, MD 20707                                                                                            |  |                                                                                      |                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Breast Cancer<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                      | Approximate interval Between Onset and Death<br>1 Year                                                                                      |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Severe Coronary Artery Disease                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                      | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                      | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                             |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                           | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |                                           | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |                                           | 29c. LICENSE NUMBER<br>D26250                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/30/95                                      |                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Matilda H. So, 1447 York Road, Lutherville, Maryland 21093                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |                                           | 32. REGISTRAR'S SIGNATURE<br>                                                                                    |  |                                                                                      |                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36294

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>William H. Harmeyer</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <i>November</i> DAY <i>27</i> YEAR <i>1995</i>                                                                                                                        |  |                                                                                  |  | 3. TIME OF DEATH<br><i>3 A M</i>                                                                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br><i>705-09-7599</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><i>1 M</i> <input type="checkbox"/> F                                                                                                                                                                                                                                                |  | 6. AGE (In yrs. last birthday)<br><i>87</i> YRS.                                                                                                                                                |  | IF UNDER 1 YEAR<br>MONTHS <i>0</i> DAYS <i>0</i>                                 |  | IF UNDER 24 HRS.<br>HOURS <i>0</i> MIN. <i>0</i>                                                                                        |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>OCTOBER 16, 1908</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>MARYLAND</i>                                                                                                                                     |  |                                                                                  |  |                                                                                                                                         |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>LAUREL REGIONAL HOSPITAL</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>LAUREL</i>                                                                                                                                            |  |                                                                                  |  | 9c. COUNTY OF DEATH<br><i>PRINCE GEORGE</i>                                                                                             |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |
| 10a. STATE<br><i>MARYLAND</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><i>PRINCE GEORGE</i>                                                                                                                                                                                                                                                            |  | 10c. CITY, TOWN OR LOCATION<br><i>LAUREL</i>                                                                                                                                                    |  |                                                                                  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><i>7806 BROOKLYN BRIDGE ROAD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><i>20707</i>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                      |  |                                                                                                                                         |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |                                                                                  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>                                                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i>0</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>SUPERVISOR</i>                                                              |  |                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>RAILROAD</i>                                                                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>GEORGE F. HARMEYER</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>HELENE STOLZE</i>                                                                                                                       |  |                                                                                  |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>MABEL C. HARMEYER</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>7806 BROOKLYN BRIDGE ROAD, LAUREL, MARYLAND 20707</i>                                       |  |                                                                                  |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>TRINITY E.L. CHURCH CEMETERY</i>                                                                          |  | DATE<br><i>11/29</i>                                                             |  | 20c. LOCATION — City or Town, State<br><i>JOPPA TOWNE, MARYLAND</i>                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Calvin S. Scales</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><i>FLECK FUNERAL HOME, INC.<br/>7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707</i>                                                                          |  |                                                                                  |  |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac arrest</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div>           a. <i>Ventricular fibrillation</i><br/>           b. <i>Pneumonia</i><br/>           c. <i>Coronary artery disease</i> </div> <div>           Approximate Interval Between Onset and Death<br/> <i>1/2 hour</i><br/> <i>1/2 hour</i><br/> <i>5 days</i> </div> </div> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Fever</i><br><i>Hypertension</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><i>M</i>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                       |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                  |  |                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Timothy P. McClain MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><i>D 39532</i>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>11/27/95</i>                           |  |                                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Timothy P. McClain 321 Prince George St Laurel MD 20707</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 30 1995</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Kordell</i>                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36295

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                               |                                              |                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Rodrickus Howell</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |                                                  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>28</b> YEAR <b>95</b>                                                                                                                              |                                              | 3. TIME OF DEATH<br><b>8 P.</b>                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-70-0709</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                | 6. AGE (In yrs. last birthday)<br><b>35 yrs.</b> | 7a. IF UNDER 1 YEAR<br>MONTHS <b>5</b> DAYS <b>20</b>                                                                                                                                         | 7b. IF UNDER 24 HRS.<br>HOURS <b>60</b> MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5-20-60</b>                                           |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>6824 STURBRIDGE LANE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                           |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto. Md.</b>                                                                                                                                      |                                              | 9c. COUNTY OF DEATH<br><b>N.A.</b>                                                              |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                               |                                              |                                                                                                 |  |
| 10a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10b. COUNTY<br><b>N.A.</b>                                                                                                                                                                                                                                                                                |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>                                                                                                                                                   |                                              | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6824 STURBRIDGE LANE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                           |                                                  | 10f. ZIP CODE<br><b>21234</b>                                                                                                                                                                 |                                              | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                        |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                              |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                              | 14. RACE - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3 1/2 yrs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>minister of music</b>                                                                                                                                                                    |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>churches</b>                                                                                                                                             |                                              |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CHARLES H. Howell</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Beraldine Bennett</b>                                                                                                                 |                                              |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>SERALDINE Howell</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                           |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2109 Southern Ave Balto. Md 21214</b>                                                     |                                              |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkview mem PK 12/5</b>                                                                                                                                                                                            |                                                  | 20c. LOCATION - City or Town, State<br><b>3310 Taylor Ave</b>                                                                                                                                 |                                              |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph B. Locks</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>Locks Funeral Home 1304 N. Central St</b>                                                                                                              |                                              |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Acquired immunodeficiency disorder</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate interval between Onset and Death<br><b>1 week</b><br><b>years</b> |  |                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                               |                                              |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Malaria</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                               |                                              |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                               |                                              |                                                                                                 |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                               |                                              |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                               |                                              |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                               |                                              |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                    |                                                  | 28b. TIME OF INJURY<br>M <b>11</b>                                                                                                                                                            |                                              | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 28d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                    |                                                  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                             |                                              |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                              |                                                  |                                                                                                                                                                                               |                                              |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                          |  |                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                               |                                              |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Bayinnah Shabazz MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |                                                  | 29c. LICENSE NUMBER<br><b>D24592</b>                                                                                                                                                          |                                              | 29d. DATE SIGNED (Month, Day, Year)<br><b>30 Nov 95</b>                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 29) (Type, Print)<br><b>BAYINNAB SHABAZZ - 2201 Cedar Circle Dr - 21228</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                               |                                              |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                           |                                                  | 32. REGISTRAR'S SIGNATURE<br><b>Shuckler</b>                                                                                                                                                  |                                              |                                                                                                 |  |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 36296

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Walter E Hildebrandt</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 27, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>8:50 A M</b>                                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-05-1053</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 14, 1919</b>                                                                                                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Bel Air Nursing &amp; Rehab. Center</b>                                                                                    |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bel Air</b>                                                                                                                          |  |
| 9c. COUNTY OF DEATH<br><b>Harford</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                   |  | 10b. COUNTY<br><b>Harford</b>                                                                                                                                                  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Bel Air</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>805 Lida Place</b>                                                                                                                                |  |
| 10f. ZIP CODE<br><b>21014</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                        |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>7th grade</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Salesman</b>                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Baking Company</b>                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Walter Hildebrandt</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lilly Mae Stinert</b>                                                                                                                   |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dennis Hildebrandt (son)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2813 Brockton Drive, Kingsville, MD 21087</b>                                               |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, repository or other place)<br><b>St. Joseph's Cemetery</b>                                                                                |  | 20c. LOCATION — City or Town, State<br><b>11/30 Baltimore, Maryland</b>                                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Matthew E. Cyp</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Schimunek Funeral Homes, Inc.<br/>9705 Belair Rd., Baltimore, MD 21236</b>                                                                               |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Colon Cancer</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. <b>Bladder Cancer</b><br><br>c.<br><br>d.<br><br>Approximate interval between Onset and Death<br><b>unknown</b><br><b>unknown</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                        |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                         |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                    |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kellie B Smaldore DO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>H40582</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/27/95</b>                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kellie B Smaldore DO 2021 Emmorton Rd Bel Air MD 21015</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>Juli Anderson-Randall</b>                                                                                                                                       |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36297

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BERTHA HARRISON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>28</b> YEAR <b>1995</b>                                                                                                                                  |  | 3. TIME OF DEATH<br><b>12:00 PM</b>                                                  |                                                                                                           |
| 4. SOCIAL SECURITY NUMBER<br><b>216-20-2770</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12/25/1918</b>                             |                                                                                                           |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1001 N. Payson Street (res.)</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                    |                                                                                                           |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                      |                                                                                                           |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 10e. STREET AND NUMBER<br><b>1001 N. Payson Street</b>                                                                                                                                              |  |                                                                                      |                                                                                                           |
| 10f. ZIP CODE<br><b>21217</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                         |  |                                                                                      |                                                                                                           |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATHS                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>              |                                                                                                           |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Specify only highest grade completed)<br><b>Maintenance</b>                                                                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Hotels</b>                                                                                                                                                     |  |                                                                                      |                                                                                                           |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Martin Gladney</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma (Unknown)</b>                                                                                                                          |  |                                                                                      |                                                                                                           |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Louis Kennedy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1001 N. Payson Street, Balto., MD 21217</b>                                                     |  |                                                                                      |                                                                                                           |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                       |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery 12/4</b>                                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                                   |  |                                                                                      |                                                                                                           |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE 21207</b>                                                                              |  |                                                                                      |                                                                                                           |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. CORONARY ARTERY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. HYPERTENSION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      | Approximate Interval Between Onset and Death<br><b>1 DAY</b><br><b>10 YEARS</b><br><b>20 YEARS</b>        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>OBESITY</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                           |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                           |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                           |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                           |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                      |                                                                                                           |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                      |                                                                                                           |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                           |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Deepak Sethi</i>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D33407</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/29/95</b>                               |                                                                                                           |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DEEPAK SETHI, M.D. 5411 OLD FREDERICK RD, BALTIMORE 21229</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                           |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>                                                                                                                                           |  |                                                                                      |                                                                                                           |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>TIMOTHY HOOD SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 28 1995</b>                                                                                                                                        |  | 3. TIME OF DEATH<br><b>12:49 P.M.</b>                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-90-3826</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br><b>30 YRS.</b>                                                                                                                            |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>9 24 65</b>                                        |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>Baltimore City</b>                                                    |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>Balto. City</b>                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>525 Chateau Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><b>21212</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>JANITOR</b>                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>ARA</b>                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James E. Hood, Jr</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Flossie Dudley</b>                                                                                                                      |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>James E. Hood, Jr</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>525 Chateau Avenue Baltimore, Md. 21212</b>                                                 |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gruid ridge 12/1/95</b>                                                                                                                                                                               |  | 20c. LOCATION — City or Town, State<br><b>Pikesville Md.</b>                                                                                                                                    |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Phillie E. Howell</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Unity Funeral Home 108 W. north Avenue Balto. Md. 21201</b>                                                                                              |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SFPSIS</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>AIDS</b><br>c.<br>d.<br>Approximate Interval Between Onset and Death<br><b>24 hrs</b><br><b>Chronic</b> |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Nonicide                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                               |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Hazen Andary M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>P-06-064</b>                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 28, 1995</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HAZEM AL-ANDARY GOOD SAM. HOSP. OF MARYLAND INC.</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>                                                                                                                                      |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.



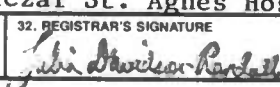
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ENRIETTA HAYNES (MN-OZORA)</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 20, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>22:18 P. M.</b>                                                                                                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-16-5864A</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>DEC. 9, 1921</b>                                                                                                                          |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                           |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                       |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                              |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>2500 RUSCOMBE LANE</b>                                                                                                                                    |  |
| 10f. ZIP CODE<br><b>21215</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                                                                                                                                        |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                              |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                                                                                                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th GRADE</b><br>College (1-4 or 5+) <b>BAR MANAGER</b>                                                                                                                                                                                                                                                                    |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>BAR MANAGER</b>                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>WORTHINGTON HALL</b>                                                                                                                              |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>REV. ADOLPH HAYNES</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARGARET JACKSON</b>                                                                                                                        |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROBERT HAYNES</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3232 TIOGA PARKWAY, BALTIMORE, MARYLAND 21215</b>                                               |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LINCOLN MEMORIAL CEMETERY 11-25-95 SUTLAND, MARYLAND</b>                                                      |  | 20c. LOCATION — City or Town, State                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.<br/>1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</b>                                                                   |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| a. <b>ADULT RESPIRATORY DISTRESS SYNDROME</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| b. <b>BRONCHOPNEUMONIA, CONFLUENT, BILATERAL</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| c. <b>KLEBSIELLA</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| d.                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pulmonary Embolus; Status Post Surgery for Abdominal Aortic Aneurysm</b>                                                                                                                                                                                                                            |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>X <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>X <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined                                                                                     |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                     |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 29c. LICENSE NUMBER<br><b>D09990</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>November 21, 1995</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Michael E. Pelczar St. Agnes Hospital 900 Caton Avenue Baltimore, MD 21229</b>                                                                                                                                                                                                                                                     |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT L. HUDSON</b>                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>21</b> YEAR <b>1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 3. TIME OF DEATH<br><b>4:10 P. M.</b>                                                                                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-07-7598</b>                                                                                                                                                                                                                               |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1-16-1914</b>                                                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>4 H BALDWIN CT.</b>                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 9c. COUNTY OF DEATH<br><b>CITY</b>                                                                                                      |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                         |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 10e. STREET AND NUMBER<br><b>4 -H - BALDWIN CT.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         |  |
| 10f. ZIP CODE                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                           |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                 |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABORER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>DAVIS CHEMICALS</b>                                                                                |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>MILTON HUDSON</b>                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BERTHA HUDSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CELLAN HUDSON</b>                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4-H BALDWIN COURT CATONSVILLE, MARYLAND 21228</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEM. PARK 11/25/95</b>                                                                                                                                                                        |  | 20c. LOCATION — City or Town, State<br><b>ARBUTUS, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                         |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>ESTEP BROTHERS FUNERAL HOME PA.<br/>1300 EUTAW PLACE BALTIMORE, MARYLAND 21217</b>                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Pancreatic Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                             |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                             |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                              |  |                                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Neil S. Friedman</i>                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>042178</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/22/95</b>                                                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Neil S. Friedman 4000 Old Court Rd. Ste. 306 Balto, MD 21208</b>                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Hudson-Randall</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DON JUAN JONES                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 27, 1995                                                                                                                                                                                                                                                    |  |                                                                                                 |                                                                  | 3. TIME OF DEATH<br>1000 A.M.                                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br>218-86-3016                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br>22 YRS.                                                                                                                                                                                                                                                                  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>JAN. 13, 1973                                         |                                                                  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>JOHNS HOPKINS HOSPITAL                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                           |  |                                                                                                 |                                                                  | 9c. COUNTY OF DEATH<br>N/A                                                                          |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br>N/A                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE                                                                                                                                                                                                                                                                   |  |                                                                                                 |                                                                  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>3810 Greenmount Avenue                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  | 10f. ZIP CODE<br>21218                                                                                                                                                                                                                                                                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                         |                                                                  |                                                                                                     |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  |                                                                                                 | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK |                                                                                                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Laborer                                                                                                                                                                                   |  |                                                                                                 | 15b. KIND OF BUSINESS/INDUSTRY<br>Auning Company                 |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Gregory Jones                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Cheryl Waters                                                                                                                                                                                                                                         |  |                                                                                                 |                                                                  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type, Print)<br>Cheryl Waters                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3810 Greenmount Ave Balto. Md. 21218                                                                                                                                                                      |  |                                                                                                 |                                                                  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of institution, crematory or other place)<br>Western Star Cem 12/4                                      |  | 20c. DATE<br>12/4                                                                                                                                                                                                                                                                                          |  | 20d. LOCATION — City or Town, State<br>Catonsville Md                                           |                                                                  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Gloria Adams Jones                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br>MARSHALL W Jones Jr RAPA<br>4401 Edmondson Ave Balto. Md 21229                                                                                                                                                                                                         |  |                                                                                                 |                                                                  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Gunshot Wound to Head                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                     |  |                                                                                                 |                                                                  |                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                 |                                                                  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide                                                                                                                                    |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>11/26/95                                                                                            |  | 28b. TIME OF INJURY<br>1700 M                                                                                                                                                                                                                                                                              |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                  | 28d. DESCRIBE HOW INJURY OCCURRED<br>Subject shot                                                   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>STREET                                                                                                                                                                                                                                                                                                                             |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>1634 E. 32nd St.                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
| 29a. CERTIFIER (Check only)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Laron Locke MD                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  | 29c. LICENSE NUMBER<br>O.C.M.E.                                                                                                                                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br>NOVEMBER 28, 1995                                        |                                                                  |                                                                                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Laron Locke, MD 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |                                                                  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br>John Anderson                                                                                                                                                                                                                                                                 |  |                                                                                                 |                                                                  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36302

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Steven Jones (MN - ROGER)</b>                                                                                                                                                                                                              |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 27 1995</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 3. TIME OF DEATH<br><b>11:40 A M</b>                                                                                                                                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-54-9625</b>                                                                                                                                                                                                                                           |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>46</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                 |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>AUG 10, 1949</b>                                                                                                                          |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                               |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>BAYVIEW MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                         |  |                                                                                |  | 10a. STATE<br><b>DC</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY                                                                                                                                                                            |  |
| 10c. CITY, TOWN OR LOCATION<br><b>WASHINGTON</b>                                                                                                                                                                                                                                          |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>2901 18th ST. NW</b>                                                                                                                                      |  |
| 10f. ZIP CODE<br><b>20009</b>                                                                                                                                                                                                                                                             |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                          |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  |                                                                                                                                                                                        |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                                                                                                                                                                                                                |  |                                                                                |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>7 yrs</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>RESEARCH ANALYST CITY GOVERNMENT</b>                                                                                                                                  |  |                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ROGER JONES</b>                                                                                                                                                                                                                             |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>TEXANNA QUEEN</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DORRESE LOMAX</b>                                                                                                                                                                                                                                |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2725 BOOKERT DR. BALTIMORE, MD. 21225</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                           |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY 11-30-95 GLEN BURNIE, MD.</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                             |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.<br/>1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                 |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>retroviral syndrome</b>                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| b. <b>pneumonia</b>                                                                                                                                                                                                                                                                       |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| c. <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>                                                                                                                                                                                                                                                |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                    |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                 |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                               |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                       |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                     |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11/28/95</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |
| 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                           |  |                                                                                |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURED                                                                                                                                                                                                                                                          |  |                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                              |  |                                                                                |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kenneth K. O'Connell</b>                                                                                                                                                                                                                      |  |                                                                                |  | 29c. LICENSE NUMBER<br><b>N3807</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                        |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>11/28/95</b>                                                                                                                                                                                                                                    |  |                                                                                |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOHNS HOPKINS BAYVIEW 5200 EASTERN AVE</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                   |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36303

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN JOSEPH KIRMIL Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>24</b> YEAR <b>1995</b>                                                                                                           |  | 3. TIME OF DEATH<br><b>6:55 PM</b>                                                                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>025-07-1298</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec 10, 1914</b>                                                                                          |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                   |  |
| 10a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Catonsville</b>                                                                                                   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>1204 McCurley Avenue</b>                                                                                                                          |  | 10f. ZIP CODE<br><b>21228</b>                                                                                                                       |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES        |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                                                                                                     |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>         |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Meat Inspector</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Government</b>                                                                                                                            |  |                                                                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Damonic Kirmil</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Markelonis</b>                                                                                                    |  |                                                                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Emily Kirmil</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1204 McCurley Avenue, Catonsville, Md. 21228</b>                           |  |                                                                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park</b>                                                                          |  | 20c. LOCATION — City or Town, State<br><b>11/27 Baltimore, Md.</b>                                                                                  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>► Peter S. Quish</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Sterling Ashton Funeral Home<br/>736 Edmondson Avenue, Balto, Md 21228</b>                                                              |  |                                                                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDIAL INFARCT</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>DIABETES MELLITUS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  | Approximate interval Between Onset and Death<br><b>9 days</b><br><b>12 days</b><br><b>7 years</b>                                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Failure</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                               |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |                                                                                                                                                     |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                    |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                   |  |                                                                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>WHS MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>P.O. 9886</b>                                                                                                                                        |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>► NOV 24 1995</b>                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RUS VIOLETA, ST AGNES HOSP., 900 CATON AVE, 21229</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><b>Juli...</b>                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                |  |                                                                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36304

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                              |  |                                                                                                                                                                                               |  |                                                                                                 |                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Manuel S. Keyser</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>27</b> , YEAR <b>1995</b>                                                                                                                    |  | 3. TIME OF DEATH<br><b>7:03 A</b> M                                                             |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>578-12-5370A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.                                                                                                                                              |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Oct. 22, 1918</b>                                  |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Manor Care - Potomac</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Potomac</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                        |                                                                                                       |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                              |  |                                                                                                                                                                                               |  |                                                                                                 |                                                                                                       |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br><b>Potomac</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>10714 Potomac Tennis Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                              |  | 10f. ZIP CODE<br><b>20854</b>                                                                                                                                                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |                                                                                                       |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 Yrs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Merchant</b>                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Tanens Sales Co.</b>                                                                                                                                     |  |                                                                                                 |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Abraham Keyser</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ethel Gottlieb</b>                                                                                                                    |  |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Hyman Keyser</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4309 Emden Street, Wheaton, Maryland 20906</b>                                            |  |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery)<br><b>Beth Shalom Congregation Cemetery</b>                                                            |  | 20c. LOCATION — City or Town, State<br><b>Capitol Heights, MD</b>                                                                                                                             |  | 20d. DATE<br><b>11/29/1995</b>                                                                  |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald C. Stottmeyer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.<br/>232 CARROLL STREET, N.W., WASHINGTON, DC 20012</b>                                                        |  |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PARKINSON'S DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                              |  |                                                                                                                                                                                               |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>YEARS</b>                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                              |  |                                                                                                                                                                                               |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                              |  |                                                                                                                                                                                               |  |                                                                                                 |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                              |  |                                                                                                                                                                                               |  |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                                          |  | 26. PLACE OF DEATH (Check only one)<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                    |  |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                    |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                               |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |                                                                                                       |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                              |  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                             |  |                                                                                                 |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                            |  |                                                                                                                                                              |  |                                                                                                                                                                                               |  |                                                                                                 |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>ASL MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                              |  | 29c. LICENSE NUMBER<br><b>D36797</b>                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov. 27, 1995</b>                                     |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>A. Sheff, MD 10215 Fernwood Road, Bethesda, Maryland 20817</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                              |  |                                                                                                                                                                                               |  |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><b>John Andrew Carroll</b>                                                                                                                                       |  |                                                                                                 |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36305

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |                                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Donald L. Lassell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 25, 1995                                                                                                                                             |  |                                                                                                 |  | 3. TIME OF DEATH<br>6:42p M                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br>037 26 2065                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>74 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>March 23, 1921                                           |  | 8. BIRTHPLACE (State or Foreign Country)<br>Massachusetts                                                                                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Montgomery General Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Olney                                                                                                                                                        |  |                                                                                                 |  | 9c. COUNTY OF DEATH<br>Montgomery                                                                                                                      |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |                                                                                                                                                        |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br>Montgomery                                                                                                                                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br>Olney                                                                                                                                                                |  |                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br>18313 Wachs Terrace                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>20832                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                            |  |                                                                                                                                                        |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |                                                                                                 |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                                                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>College (1-4 or 5+)<br>5                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Captain                                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>United States Navy                                                                                                                                                |  |                                                                                                 |  |                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Lassell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Viola Dunn                                                                                                                                     |  |                                                                                                 |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ruth E. Lassell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>same as #10 above                                                                                  |  |                                                                                                 |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Arlington National Cem 12/6                                                                                                                                                                                             |  |                                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br>Arlington, Virginia                                      |  |                                                                                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>Ives-Pearson Funeral Homes<br>Arlington, VA 22201                                                                                                               |  |                                                                                                 |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Dilated Cardiomyopathy<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Aortic and mitral valvular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Post op aortic valve replacement<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. Post op mitral valve annuloplasty |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  | Approximate Interval Between Onset and Death<br>20 hours<br>years<br>1 Nov 95<br>1 Nov 95                                                              |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypoxic encephalopathy due to witnessed cardiac arrest at home                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                 |  |                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                          |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                      |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  |                                                                                                 |  |                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>DC45809                                                                                                                                                                      |  | 29d. DATE SIGNED (Month, Day, Year)<br>11-26-95                                                 |  |                                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JOHN G. LODMELL MD, 2901 Olney Rd, Olney, Md 20832                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                     |  |                                                                                                 |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36306

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Bernard W Lane</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <i>November</i> DAY <i>1</i> YEAR <i>1995</i>                                                                                                                         |  | 3. TIME OF DEATH<br><i>2:30 A.M.</i>                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br><i>114-20-6921</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><i>66</i> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>9-2-1929</i>                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Laurel Regional Hospital</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Laurel</i>                                                                                                                                            |  | 9c. COUNTY OF DEATH<br><i>Prince George</i>                                                 |  |
| 10a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><i>Prince George</i>                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br><i>Laurel</i>                                                |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 10e. STREET AND NUMBER<br><i>9262 Cherry Lane # 38</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><i>20708</i>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                 |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i><br>College (1-4 or 6+) <i>0</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Purchaser</i>                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Fire Protection Company</i>                                                                                                                                |  |                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Walter Lane</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Pearl Burchard</i>                                                                                                                      |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Billie B. Lane</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>9262 Cherry Lane # 38 Laurel, MD 20708</i>                                                  |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Meadowridge Mem. Park 11-25-95</i>                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br><i>Dorsey, Maryland</i>                                                                                                                                  |  |                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Collette Gulecky</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Fleck Funeral Home, Inc.<br/>7601 Sandy Spring Road Laurel, MD 20707</i>                                                                                 |  |                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary Artery Disease</i><br>Approximate Interval Between Onset and Death <i>minutes</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Insulin Dependent Diabetes Mellitus</i> DUE TO (OR AS A CONSEQUENCE OF):<br>d. <i>Insulin Dependent Diabetes Mellitus</i> DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death <i>Days</i><br><i>Years</i> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                         |  |                                                                                             |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><i>M</i>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William A. Warren</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><i>D13916</i>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>November 21, 1995</i>                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>William A. Warren 321 Prince George St Laurel MD 20707</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 30 1995</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John Anderson</i>                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36307

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Beato J. Lerum</i>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>November 21<sup>st</sup> 1995</i>                                                                                                                          |  | 3. TIME OF DEATH<br><i>12:50 p.m.</i>                                                                                                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>579-64-2282</i>                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>73</i> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>May 9<sup>th</sup> 1922</i>                                                                                                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Philippines</i>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><i>R. Adams Cowley Shock Trauma Center</i>                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore MD</i>                                                                                                                             |  |
| 9c. COUNTY OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 10a. STATE<br><i>Maryland</i>                                                                                                                                                                       |  | 10b. COUNTY<br><i>Prince George</i>                                                                                                                                                    |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Upper Marlboro</i>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><i>18 Sutton Court</i>                                                                                                                                       |  |
| 10f. ZIP CODE<br><i>20772</i>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                                                                         |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |                                                                                                                                                                                        |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>Pacific Islander</i>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>6</i>                                                               |  |                                                                                                                                                                                        |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Accountant</i>                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Medical</i>                                                                                                                                                    |  |                                                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Juan Lerum</i>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Maria Salud Juvida</i>                                                                                                                      |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Natividad D. Lerum</i>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>18 Sutton Court Upper Marlboro, MD 20772</i>                                                    |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                 |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>MD Natl. Mem. Park 11-27-95 Laurel, Maryland</i>                                                              |  |                                                                                                                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Fleck Funeral Home, Inc.<br/>7601 Sandy Spring Road Laurel, MD 20707</i>                                                                                     |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                       |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death)<br><i>Septic Shock</i>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| b. <i>Aplastic Anemia</i>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| c. <i>Necrotizing Fasciitis</i>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| Approximate Interval Between Onset and Death<br><i>11 days</i><br><i>15 days</i><br><i>15 days</i>                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                          |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                     |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                             |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                    |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                  |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURED                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 29. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature] House Staff</i>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 29b. LICENSE NUMBER<br><i>AV4176435 Am-2768</i>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 29c. DATE SIGNED (Month, Day, Year)<br><i>November 21<sup>st</sup> 1995</i>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Steven F. Melius MD UMMS 22 S. Green St.</i>                                                                                                                                                                                                                                                                                          |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 30 1995</i>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36308

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Paul E. Lippy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 24, 1995</b>                                                                                                                                                                                                                                                                                                                                                               |  | 3. TIME OF DEATH<br><b>9:29 P. M.</b>                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-10-7326</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.                                                                                                                                                                                                                                                                                                                                                                             |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 1, 1908</b>                       |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Northwest Hospital Center</b>                                                                                                                                                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Randallstown</b>                       |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                  |  |
| 10b. COUNTY<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 10e. STREET AND NUMBER<br><b>1400 Dellwood Avenue</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                  |  |
| 10f. ZIP CODE<br><b>21211</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>       |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>Musician</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>Music</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Lippy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rose Nusbaum</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jacqueline Elfert</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2109 Triandos Drive, Timonium, Maryland 21093</b>                                                                                                                                                                                                                                                                        |  |                                                                                  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Poplar Grove Cemetery</b>                                                                                                                                                                             |  | DATE<br><b>11/28</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20c. LOCATION — City or Town, State<br><b>Cockeysville, Maryland</b>             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ryann Burgee-Henss</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Burgee-Henss Funeral Home, 21211<br/>3631 Falls Road, Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                                  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Shonda Richards MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>D31296</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 24, 1995</b>                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Northwest Hospital Center 5401 Old Court Rd, Randallstown MD 21133</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><i>Shonda Richards</i>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36309

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Jessie MAE Lucas</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 27, 1995</b>                                                                                                                                  |  | 3. TIME OF DEATH<br><b>5:05 p m</b>                                                             |                                                                                                                                                    |
| 4. SOCIAL SECURITY NUMBER<br><b>246-10-5415</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (in yrs. last birthday)<br><b>79 YRS.</b>                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>NOV. 01, 1916</b>                                  |                                                                                                                                                    |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BAYVIEW NURSING HOME</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                               |                                                                                                                                                    |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                                    |
| 10e. STREET AND NUMBER<br><b>2000 ODELL AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21237</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                                    |                                                                                                                                                    |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                      |                                                                                                                                                    |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN</b><br>College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>FACTORY WORKER</b>                                                                                                                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>TOBACCO FACTORY</b>                                                                                                                                        |  |                                                                                                 |                                                                                                                                                    |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>PAUL FREEMAN</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LUCY WRIGHT</b>                                                                                                                         |  |                                                                                                 |                                                                                                                                                    |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DEBORAH PARKER</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>45 N. ABINGTON AVENUE, BALTIMORE, MARYLAND 21229</b>                                        |  |                                                                                                 |                                                                                                                                                    |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LOUDON PARK CEMETERY 12-01-95</b>                                                                                                                                                                        |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>                                                                                                                               |  |                                                                                                 |                                                                                                                                                    |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.<br/>1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</b>                                                               |  |                                                                                                 |                                                                                                                                                    |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death                                                                                                       |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cerebrovascular Accident</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | <b>2 days</b>                                                                                                                                      |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| b. Aspiration Pneumonia                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | <b>5 days</b>                                                                                                                                      |
| c. Septicemia                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | <b>6 days</b>                                                                                                                                      |
| d.                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Bullous pemphigoid, IDDM, CHF, chronic renal insufficiency, HTN</b>                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                    |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |                                                                                                                                                    |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |                                                                                                                                                    |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>96002</b>                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 28, 1995</b>                                 |                                                                                                                                                    |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Johns Hopkins Bayview Medical Center</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                   |  |                                                                                                 |                                                                                                                                                    |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate must be signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Heath Anne Metcalf</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH <i>November</i> DAY <i>21</i> YEAR <i>1995</i>                                                                                                                            |  |                                                                                      |  | 3. TIME OF DEATH<br><i>11:50 P</i>                                                                                                          |  |
| 4. SOCIAL SECURITY NUMBER<br>214-58-4603                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br>65 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>10-25-1930                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Washington, DC                                                                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>13302 Deerfield Road Apt. 102                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                 |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Laurel                                                                                                                                                       |  |                                                                                      |  | 9c. COUNTY OF DEATH<br>Prince George                                                                                                        |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br>Prince George                                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br>Laurel                                                                                                                                                               |  |                                                                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br>13302 Deerfield Road Apt. 102                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                 |  | 10f. ZIP CODE<br>20708                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                 |  |                                                                                                                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |                                                                                                                                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (8-12) <i>12</i> College (1-4 or 5+) <i>0</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                                                                                                                                                                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home                                                                                                                                                          |  |                                                                                      |  |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Joseph M. Schriefer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary A. McDermott                                                                                                                              |  |                                                                                      |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Arnold Metcalf                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13302 Deerfield Road Apt. 102, Laurel, MD 20707                                                    |  |                                                                                      |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Balt. Wash. Crematory 11-25-95                                                                                                                                                                               |  | 20c. LOCATION — City or Town, State<br>Laurel, Maryland                                                                                                                                             |  |                                                                                      |  |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles J. Leary</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                 |  | 22. NAME AND ADDRESS OF FACILITY<br>Fleck Funeral Home, Inc.<br>7601 Sandy Spring Road Laurel, MD 20707                                                                                             |  |                                                                                      |  |                                                                                                                                             |  |
| 23. PART I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute myocardial infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |  | Approximate Interval Between Onset and Death                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                         |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                       |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                           |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                 |  | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                      |  |                                                                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                       |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Augusto P. Rodriguez M.D.</i>                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br>D21230                                                        |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>November 23, 1995</i>                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Augusto P. Rodriguez M.D. 5009 Rayburn Ct., Camp Springs, MD 20748                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 5 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36311

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Marion Morton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>27</b> YEAR <b>95</b>                                                                                                                               |  | 3. TIME OF DEATH<br><b>7:06 P M</b>                                                             |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>225-14-1398</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>April 21, 1916</b>                                 |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>VA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Bon Secours Hospital</b>                                                                                                   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto</b>                                             |                                                                                                       |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 10a. STATE<br><b>md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                                                                                                                   |  | 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>823 n. Payson st.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><b>21217</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES<br><b>WWII</b>                                                                                                                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (14 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 16a. OCCUPATION'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Steel Worker</b>                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>steel</b>                                                  |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Marrell Morton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jennie Davis</b>                                                                                                                        |  |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Alice L. Morton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>823 n. Payson st. Balto, md 21217</b>                                                       |  |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet</b>                                                                                                                                                                               |  | 20c. LOCATION — City or Town, State<br><b>12/1/95 Owings Mills md</b>                                                                                                                           |  |                                                                                                 |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Glynis B. Harris</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F.H. West<br/>4300 Wabash Ave</b>                                                                                                                  |  |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>acute myo cardiac infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>complete heart block</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>congestive heart failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>atherosclerotic disease</b> |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate interval Between Onset and Death<br><b>1 day</b><br><b>1 day</b><br><b>10 yrs.</b>        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                           |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Marcelino A. Alverne md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>D29769</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/28/95</b>                                          |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Marcelino A. Alverne md 516 n. Rolling Rd Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 8 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><b>Jane [Signature]</b>                                                                                                                                            |  |                                                                                                 |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 36312

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Helen Marsteller</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>3</b> , YEAR <b>1995</b>                                                                                                                       |  | 3. TIME OF DEATH<br><b>11:53 A.M.</b>                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>222-14-3361</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>11-10-1927</b>                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>NEW JERSEY</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b>                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                                |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>FLORIDA</b>                                                                                                                                                                    |  | 10b. COUNTY<br><b>PALM BEACH</b>                                                            |  |
| 10c. CITY, TOWN OR LOCATION<br><b>JUPITER</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>18366 LAKE BEND DRIVE</b>                                      |  |
| 10f. ZIP CODE<br><b>33458</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                     |  |                                                                                             |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES <b>XX</b>                                                                                                                                         |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>00</b>                                                                                                                                                                                                                                                                                    |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>VICE PRES.</b>                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>MARSTELLER'S DAIRY MKTS.</b>                                                                                                                               |  |                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOSEPH X. KAUFFMAN</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LOVINA YOUNG</b>                                                                                                                        |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>WILLARD PAUL MARSTELLER</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18366 LAKE BEND DRIVE, JUPITER, FLA. 33458</b>                                              |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SHARON HILL MEMORIAL PARK 11-7-1995 DOVER, DEL.</b>                                                                                                                                                      |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  | 20d. DATE                                                                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Thomas R. Trader</i>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>TRADER FUNERAL HOME INC.<br/>12 LOTUS ST. DOVER, DEL.</b>                                                                                                |  |                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  | a. <b>presumed internal hemorrhage</b>                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  | Approximate Interval Between Onset and Death<br><b>1 day</b>                                |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                     |  | b. <b>end stage liver disease</b>                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  | <b>1 month</b>                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | c. <b>primary biliary cirrhosis</b>                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                 |  | <b>5 years</b>                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | d.                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>hepatorenal syndrome</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Gregory Prokopowicz MD</i>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>M 6095</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 3, 1995</b>                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Gregory Prokopowicz Tower 110 Johns Hopkins Hospital Baltimore MD</b>                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 3 0 1995</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36313

ITEMS: 23 PART I, II, PER DR. FILM G-729 11/30/95 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Alberta Wilson MacGregor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 23, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>7:10 p.m.</b>                                                                                                                                           |                                                                                                                                         |
| 4. SOCIAL SECURITY NUMBER<br><b>214-40-4604</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 30, 1909</b>                                                                                                                     |                                                                                                                                         |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Ohio</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Manor Care Towson</b>                                                                                                      |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                                                                                                           |                                                                                                                                         |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                   |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                |                                                                                                                                         |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>7009 Kenleigh Road</b>                                                                                                                            |                                                                                                                                         |
| 10f. ZIP CODE<br><b>21212</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |                                                                                                                                         |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                                                        |                                                                                                                                         |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 years</b> College (1-4 or 5+) <b>Teacher</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Public Schools</b>                                                                                                                        |                                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles D. Wilson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Myrtle Grace Hays</b>                                                                                                                   |  |                                                                                                                                                                                |                                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Phyllis M. DeSmit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4806 Keswick Road, Baltimore, Maryland 21210</b>                                            |  |                                                                                                                                                                                |                                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Mausoleum</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Gdn's Nov. 27 Timonium, Maryland</b>                                                  |  |                                                                                                                                                                                |                                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Thomas Joseph Reel</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home Inc.<br/>6500 York Rd. Baltimore, MD 21212</b>                                                                                   |  |                                                                                                                                                                                |                                                                                                                                         |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CONGESTIVE HEART FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. CORONARY ARTERY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                | Approximate Interval Between Onset and Death<br><b>1 YEAR</b>                                                                           |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DYSPHAGIA, STROKE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                                                         |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                               |                                                                                                                                         |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                                                                                                |                                                                                                                                         |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Michael J. Mininsohn</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D31189</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/24/95</b>                                                                                                                         |                                                                                                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Michael J. Mininsohn M.D. 8813 Waltham Woods Road, Baltimore, MD 21234</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John Howard Randall</i>                                                                                                                                         |  |                                                                                                                                                                                |                                                                                                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


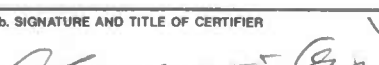





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                     |  |                                                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PHYLLIS D MACK</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>21</b> YEAR <b>1995</b>                                                                                                                                 |  | 3. TIME OF DEATH<br><b>14:15 M</b>                                                                                                                      |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-12-9122</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2/26/1925</b>                                                                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>CITY</b>                                                                                                                      |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. COUNTY<br><b>CITY</b>                                                                                                                                                                          |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                         |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10e. STREET AND NUMBER<br><b>4210 FAIRFAX ROAD</b>                                                                                                                                                  |  |                                                                                                                                                         |  |
| 10f. ZIP CODE<br><b>21216</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                         |  |                                                                                                                                                         |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>AFR. AMERICAN</b>                                                                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>                                                                                                                                                                                                                                                                                                                         |  | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>UNKNOWN</b>                                                                                                                                                     |  |                                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JULUIS ROGERS</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>GRACE ROY</b>                                                                                                                               |  |                                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>O'DELL DESHIELDS</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2106 ALLENDALE ROAD, BALTIMORE, MARYLAND 21216</b>                                              |  |                                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY 11/24/95</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20c. LOCATION — City or Town, State<br><b>CATONSVILLE. MD.</b>                                                                                                                                      |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                         |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>ESTEP BROTHERS FUNERAL HOME, P.A.<br/>1300 EUTAW PLACE, BALTIMORE, MD. 21217</b>                                                                                                                                                                                                                                                                                                          |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARDS</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>RENAL FAILURE</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>LIVER FAILURE</b><br>c. DUE TO (OR AS A CONSEQUENCE OF): <b>SEPTIC SHOCK</b><br>d.<br><br>Approximate Interval Between Onset and Death<br><b>14 DAYS</b><br><b>7 DAYS</b><br><b>5 DAYS</b><br><b>14 DAYS</b> |  |                                                                                                                                                                                                     |  |                                                                                                                                                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>NIDDM, CAD, A-V BLOCK</b>                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                               |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                     |  | 25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                     |  |                                                                                                                                                         |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                    |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                     |  |                                                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 29c. LICENSE NUMBER<br><b>AV4176435</b>                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 21 1995</b>                                                                                               |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHUAN-YUAN QIU 22.S GREENE ST. BALTIMORE, MD # 21201</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                     |  |                                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JEROME MONTGOMERY</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 24 1995</b>                                                                                                                                        |  | 3. TIME OF DEATH<br><b>3:05 A<sup>M</sup></b>                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br><b>18</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7-1-1977</b>                                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SHOCK TRAUMA CENTER</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                                       |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                     |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO               |  |
| 10e. STREET AND NUMBER<br><b>2242 GUILFORD AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                     |  | 10f. ZIP CODE<br><b>21218</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                       |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>STUDENT</b>                                                                                                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>UNKNOWN</b>                                                                                                                                                |  |                                                                                                               |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JEROME MONTGOMERY SR.</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MICHANE BRANDFORD</b>                                                                                                                   |  |                                                                                                               |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MICHANE BRANDFORD</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>630 WYETH STREET BALTIMORE, MARYLAND 21230</b>                                              |  |                                                                                                               |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)<br><b>MT. ZION CEMETERY 11/29/95</b>                                                                                                                                                              |  | 20c. LOCATION — City or Town, State<br><b>LANSDOWN, MARYLAND</b>                                                                                                                                |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                 |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>ESTEP BROTHERS FUNERAL HOME PA.<br/>1300 EUTAW PLACE BALTIMORE, MARYLAND 21217</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Gun shot wound to neck</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input checked="" type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Could not be determined                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11-24-95</b>                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br><b>0204<sup>M</sup></b>                                                                                                                                                  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject shot.</b>                                                                                                                                                                                                                           |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Parking lot</b>                                                                                    |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>lot A at Camden Yards.</b> |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 24, 1995</b>                                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                               |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                 |  |                                                                                                               |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36316

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Philip Paul MECH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 27, 1995                                                                                                                                             |  | 3. TIME OF DEATH<br>7:25 a.m.                                                                                                               |  |
| 4. SOCIAL SECURITY NUMBER<br>212-76-2316                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             | 6. AGE (In yrs. last birthday)<br>62 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>April 21 1933                                                                                                                                                |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Franklin Square Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rossville                                                                                                                                                    |  | 9c. COUNTY OF DEATH<br>Baltimore County                                                                                                     |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                   |                                           | 10c. CITY, TOWN OR LOCATION<br>Perry Hall                                                                                                                                                           |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br>9509 PerryHall Blvd.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |                                           | 10f. ZIP CODE<br>21236                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                                                                              |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                                                            |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5<br>College (1-4 or 5 +)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Dependent                                                                                                                                                                                    |                                           | 16b. KIND OF BUSINESS/INDUSTRY<br>N/A                                                                                                                                                               |  |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John C. Mech                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Gertrude M. Krueger                                                                                                                            |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Pauline Tyler                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9509 Perry Hall Blvd. Baltimore, Md. 21236                                                         |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Gardens of Faith Cem. 11/30/95                                                                                                                                                                                          |                                           | 20c. LOCATION — City or Town, State<br>Baltimore Maryland                                                                                                                                           |  |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Milton J. Knight Jr.<br><i>Milton J. Knight Jr.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |                                           | 22. NAME AND ADDRESS OF FACILITY<br>Leonard J. Ruck, Inc.<br>5305 Harford Road Baltimore, Md. 21214                                                                                                 |  |                                                                                                                                             |  |
| 23. PART I. Enter the disease(s), or complication(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Cardiac Arrhythmia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. Metabolic acidosis<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Seizure disorder<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. Hypernatremia |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  | Approximate Interval Between Onset and Death<br>5 minutes                                                                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Status post ventral hernia repair                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                           | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |                                           | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |                                           |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Bryan Khim M.D.<br><i>Bryan Khim</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                           | 29c. LICENSE NUMBER<br>P07557                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/27/95                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Bryan Khim, M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |                                           | 32. REGISTRAR'S SIGNATURE<br><i>John Anderson Carroll</i>                                                                                                                                           |  |                                                                                                                                             |  |

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36317

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>HENRY REID PREWITT, III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 26, 1995                                                                                                                                             |  | 3. TIME OF DEATH<br>11:12 A. M.                                                                                                                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br>405-40-9147                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>62 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>AUGUST 10, 1933                                                                                                                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>KENTUCKY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br>12223 VALERIE LANE                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>LAUREL                                                                                                                                          |  |
| 9c. COUNTY OF DEATH<br>PRINCE GEORGE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 10a. STATE<br>MARYLAND                                                                                                                                                                              |  | 10b. COUNTY<br>PRINCE GEORGE                                                                                                                                                           |  |
| 10c. CITY, TOWN OR LOCATION<br>LAUREL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br>12223 VALERIE LANE                                                                                                                                           |  |
| 10f. ZIP CODE<br>20708                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>1954 - 1956                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                                                                                                       |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>ELECTRICAL ENGINEER                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>DEFENSE                                                                                                                                              |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>HENRY REID PREWITT, II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>LAURA RAY CROOKS                                                                                                                               |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>PHYLLIS A. PREWITT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12223 VALERIE LANE, LAUREL, MARYLAND 20708                                                         |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>EMMANUEL UMC CEMETERY 11/29                                                                                      |  | 20c. LOCATION — City or Town, State<br>SCAGGSVILLE, MARYLAND                                                                                                                           |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>FLECK FUNERAL HOME, INC.<br>7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707                                                                                      |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic - prostate Cancer<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | Approximate Interval Between Onset and Death<br>2 1/2 yrs.                                                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                            |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)<br>N/A                                                                                                                                                                                                                                                              |  | 28b. TIME OF INJURY<br>N/A M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>N/A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>N/A                                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>N/A                                                                                                                 |  |                                                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>41139                                                                                                                                                                        |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/27/95                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>CREWENT KNIGHT, 11065 Little Pottersent Parkway Adel, Md 21004                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                     |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36318

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELEANOR L. PRESSLEY</b>                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 26 1995</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 3. TIME OF DEATH<br><b>1240 P M</b>                                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>237-07-4255</b>                                                                                                                                                                                                                                           |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                              |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                 |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 19, 1915</b>                                                                                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>North Carolina</b>                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>Hopkins Bayview Hospital</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                        |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                        |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><b>9 Tulip Tree Court</b>                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><b>21221</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                         |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th grade</b>                                                                                                                                                                          |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Waitress</b>                                                                                                                                                                                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Restaurant</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Jack Butler Matthews</b>                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Kate Brewton</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Pat Soesbee (Daughter)</b>                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9 Tulip Tree Court, Baltimore, Maryland 21221</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                           |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory 11/28/95</b>                                                                                                                                                                                                                                                                                                                                                    |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert J. Schimunek</b>                                                                                |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Schimunek Funeral Home</b>                                                                                                                                                                                                                         |  | 23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>COPD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>lung adenoca</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><b>24 hrs</b><br><b>years</b><br><b>years</b> |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                     |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>W.A. Hoogerwerf, MD</b>                                                                                                                                                                                                                       |  | 29c. LICENSE NUMBER<br><b>95008</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/26/95</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>W.A. Hoogerwerf, JHBMC, EASTERN AVE, BALTIMORE</b>                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                   |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020


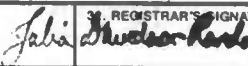
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36319

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALBERT GILROY PARLETT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>27</b> YEAR <b>1995</b>                                                                                                                        |  | 3. TIME OF DEATH<br><b>19:40 PM</b>                                                             |                                                                                                                                                    |
| 4. SOCIAL SECURITY NUMBER<br><b>213-05-6519</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                              |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10-17-1904</b>                                     |                                                                                                                                                    |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                               |                                                                                                                                                    |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>                                                                                                                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br><b>LINTHICUM</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                                    |
| 10e. STREET AND NUMBER<br><b>551 FOREST VIEW ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                         |  | 10f. ZIP CODE<br><b>21090</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |                                                                                                                                                    |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |                                                                                                                                                    |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>OFFICE PERSONNEL</b>                                                        |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CHEVRON</b>                                                |                                                                                                                                                    |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HARRY GAGER PARLETT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>DORA BELL PYLE</b>                                                                                                                      |  |                                                                                                 |                                                                                                                                                    |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>BETTY AMRHEIN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                         |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8394 BROOKWOOD ROAD, MILLERSVILLE, MD. 21108</b>                                            |  |                                                                                                 |                                                                                                                                                    |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LORRAINE PARK CEMETERY</b>                                                                                                                                                        |  | DATE <b>11/30/1995</b>                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>                               |                                                                                                                                                    |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                         |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MARYLAND 21061</b>                                                                           |  |                                                                                                 |                                                                                                                                                    |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Cancer of the tongue</b><br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>Cancer of the colon</b><br><br><b>Dementia</b><br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>2 weeks</b><br><br><b>74 months</b>                                                             |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cancer of the colon</b><br><b>Dementia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                          |  | 28b. TIME OF INJURY<br><b>M</b>                                                                 |                                                                                                                                                    |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                       |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |                                                                                                                                                    |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br><b>P08219</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 27/95</b>                                    |                                                                                                                                                    |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KASSABA ROBERT, ST. AGNES HOSP. BALTIMORE, MD, 21229</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                |  |                                                                                                 |                                                                                                                                                    |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MICHELLE Elizabeth PRESIDENT</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 22 1995</b>                                                                                                                                            |  | 3. TIME OF DEATH<br><b>2:30 A M</b>                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-86-6042</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>29</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 15, 1966</b>                                         |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                        |  | 8c. COUNTY OF DEATH<br><b>N / A</b>                                                                 |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>N / A</b>                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>906 Belgian Avenue</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 10f. ZIP CODE<br><b>21218</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                                       |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>8th</b>                                                                                                                                                                                                                                                                                                                                                    |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>assembly Line</b>               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Cosmetics</b>                                                                                                                                                  |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John President</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Evelyn Shipley</b>                                                                                                                          |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Evelyn President</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>906 Belgian Ave., Balto., Md. 21218</b>                                                         |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Baltimore Cemetery</b>                                     |  | DATE<br><b>Nov 29</b>                                                                                                                                                                               |  | 20c. LOCATION — City or Town, State<br><b>Balto., Md.</b>                                           |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Carlton C. Douglass</i>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Carlton C. Douglass</b><br><b>1701 McCulloh St. Balto, Md. 21217</b>                                                                                         |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>e. Narcotic Intoxication</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)                                                                                                              |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA             |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                   |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11-22-95</b>                                                                                        |  | 28b. TIME OF INJURY<br><b>1:20AM</b>                                                                                                                                                                |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Unknown</b>                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Found: Residence</b>                                                                                   |  |                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>906 Elgain Ave Balto, MD.</b>                                 |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Theodore M. King</i>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>O.C.M.E</b>                                                                                                                                                               |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 22, 1995</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>THE MORE M. King</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br><i>John Anderson</i>                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                     |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36321

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Una Mae Phillips                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 28 1995                                                                                                                                                |  | 3. TIME OF DEATH<br>9:50 a.m.                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br>249-18-8498                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 6. AGE (In yrs. last birthday)<br>78 YRS.                                                                                                                                                         |  | 7. DATE OF BIRTH (Month, Day, Year)<br>May 14 1917                                                                                                                                                                                                                                                                                                                                                                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>South Carolina                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br>FRANKLIN SQUARE HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE                                                                                                                                                  |  | 9c. COUNTY OF DEATH<br>BALTIMORE CO.                                                                                                                                                                                                                                                                                                                                                                                                |  |
| 10a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br>BALTIMORE CO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br>N/A                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                 |  |
| 10e. STREET AND NUMBER<br>1313 Maple Avenue                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10f. ZIP CODE<br>21221                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                                                                                                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                                                                                                                                                                                                                                                                                                                                                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11th grade<br>College (1-4 or 5+) College (1-4 or 5+)                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Care Provider                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Rosewood State Hospital                                                                                                                                                                                                                                                                                                                                                                           |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Harvey Dupree                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Sarah Dupree                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Phyllis E. Younger                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1313 Maple Avenue, Baltimore, Maryland 21221                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>XX Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Arbutus Memorial Park 12/02                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND                                                                                                                                        |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                     |  |
| 22. NAME AND ADDRESS OF FACILITY<br>WILLIAM C. BROWN COMMUNITY F/H<br>1206 W. NORTH AVENUE                                                                                                                                                                                                |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC Arrhythmia</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Atherosclerotic HEART Disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                           |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                          |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                             |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                         |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                      |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 29c. LICENSE NUMBER<br>D44604                                                                                                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/28/95                                                                                                                                                                                                                                                                                                                                                                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MICHAEL SUTER MD 8100 HARFORD Rd BALT 21234                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been filed in the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, be filed within 72 hours after death with the State Department of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-730 12/11/95 t.t

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LEE E. PRESSLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 23 1995</b>                                                                                                                                       |  | 3. TIME OF DEATH<br><b>1:22 P M</b>                                                                                                                                            |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>217-62-1866</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>41</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>DEC. 13, 1953</b>                                                                                                                    |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>SOUTH CAROLINA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>410 W. FRANKLIN STREET</b>                                                                                                 |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                        |                                                                                                       |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                   |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                      |                                                                                                       |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>410 W. FRANKLIN STREET, APT. #5A</b>                                                                                                              |                                                                                                       |
| 10f. ZIP CODE<br><b>21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                                                                                                                                    |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |                                                                                                       |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                                                                                                     |                                                                                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th GRADE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>BRICKLAYER</b>                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CONSTRUCTION COMPANY</b>                                                                                                                  |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LEROY PRESSLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BERTHA FULTON</b>                                                                                                                       |  |                                                                                                                                                                                |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>BERTHA PRESSLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2315 LAURETTA AVENUE, BALTIMORE, MARYLAND 21223</b>                                         |  |                                                                                                                                                                                |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY 12-2-95</b>                                                                             |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>                                                                                                              |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.<br/>1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</b>                                                               |  |                                                                                                                                                                                |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>NARCOTIC INTOXICATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                | Approximate interval between Onset and Death                                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input checked="" type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                          |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>FOUND ON 11/23/95</b>                                                                                                                                                                                                                             |  | 28b. TIME OF INJURY<br><b>1:00 P M</b>                                                                                                                                                          |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                    |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND AT HOME</b>                                                                                                                                                                                 |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>410 W. FRANKLIN STREET<br/>BALTIMORE, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 24, 1995</b>                                                                                                                    |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                   |  |                                                                                                                                                                                |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36323

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HORACE E. RANDOLPH</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 27, 1995</b>                                                                                                                                  |  | 3. TIME OF DEATH<br><b>5:16 P M</b>                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-30-4573</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>OCT. 8, 1932</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Bowie Medical Center</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bowie</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b>                                                   |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Prince George</b>                                                                                                                                                                                                                                                            |  | 10c. CITY, TOWN OR LOCATION<br><b>Bowie</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3015 Stonybrook Drive</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>20715</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1951 - 1954</b>                                                                                                                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                     |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Adjuster</b>                                                                                                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Insurance</b>                                                                                                                                              |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Elmer B. Randolph</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Clara Scott</b>                                                                                                                    |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Catherine Hottinger</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3015 Stonybrook Drive, Bowie, Maryland 20715</b>                                            |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>Ivy Hill Cemetery 12/1</b>                                                                                                                                                                              |  | 20c. LOCATION — City or Town, State<br><b>Laurel, Maryland</b>                                                                                                                                  |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Fleck Funeral Home, Inc.<br/>7601 Sandy Spring Road, Laurel, MD 20707</b>                                                                                |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE MYOCARDIAL INFARCTION</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D25925</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 27, 1995</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. BERGER #205, 7720 WISCONSIN Ave Bethesda MD 20814</b>                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG. NO.

DMMH-16 Rev 1/89



95 36325

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Wayne M. RAINS                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 24, 1995                                                                                                                                             |  | 3. TIME OF DEATH<br>8:57 am. M                                                                      |  |
| 4. SOCIAL SECURITY NUMBER<br>216-03-7068                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 6. AGE (In yrs. last birthday)<br>91 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Nov. 27, 1903                                                |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Hartford, Arkansas                                                                                                                                                                                                                                                                                                                                                                   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Franklin Square Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore county                                                                                                                                             |  | 9c. COUNTY OF DEATH<br>Baltimore county                                                             |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10c. CITY, TOWN OR LOCATION<br>White Marsh                                                                                                                                                          |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>11011 Pulaski Highway                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10f. ZIP CODE<br>21162                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>1921-1923                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>9th.                                                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Fisher Body                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br>General Motors Corp.                                                                                                                                              |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Henry Rains                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elizabeth Carter                                                                                                                               |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>William Rains                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11011 Pulaski Highway White Marsh, Md. 21162                                                       |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Holly Hill Memorial Gardens Nov. 27, 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland                                                                                                                                          |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>E. F. Lassahn                                          |  |
| 22. NAME AND ADDRESS OF FACILITY<br>E. F. Lassahn Funeral Home<br>11750 Belair Road Kingsville, Md. 21087                                                                                                                                                                                                                                                                                                                        |  | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. Renal failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. _____<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>A. Youssri MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br>D46263                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/24/95                                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ayman Youssri, M.D. 7419 Lesada Drive #3 Baltimore, MD 21244                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                 |  | 32. REGISTRAR'S SIGNATURE<br>John Andrew Raskin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36326

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |                                                  |                                                                                                                                                                                                                                                                                             |  |                                |  |                                                                                                 |  |                                                                                                       |  |                                                                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Lucille M. Ryan</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |                                                  | 2. DATE OF DEATH<br>MONTH <i>November</i> DAY <i>24</i> YEAR <i>1995</i>                                                                                                                                                                                                                    |  |                                |  | 3. TIME OF DEATH<br><i>5:02 A M</i>                                                             |  |                                                                                                       |  |                                                                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><i>204-05-3003</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                   | 6. AGE (In yrs. last birthday)<br><i>76</i> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                                                                                                              |  | IF UNDER 24 HRS.<br>HOURS MIN. |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Oct. 11, 1919</i>                                  |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>PA</i>                                                 |  |                                                                                                                                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>University of Maryland Medical System</i>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                     |  |                                |  | 9c. COUNTY OF DEATH                                                                             |  |                                                                                                       |  |                                                                                                                                                    |  |
| 10a. STATE<br><i>PA</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><i>York</i>                                                                                                                   |                                                  | 10c. CITY, TOWN OR LOCATION<br><i>York</i>                                                                                                                                                                                                                                                  |  |                                |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |                                                                                                       |  |                                                                                                                                                    |  |
| 10e. STREET AND NUMBER<br><i>449 East King St., Apt. 40</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                                  | 10f. ZIP CODE<br><i>17403</i>                                                                                                                                                                                                                                                               |  |                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                     |  |                                                                                                       |  |                                                                                                                                                    |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                             |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                             |  |                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                         |  |                                                                                                       |  |                                                                                                                                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+) <i></i>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |                                                  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Waitress</i>                                                                                                                                                            |  |                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Restaurant</i>                                             |  |                                                                                                       |  |                                                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Charles E. Walters</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Edith L. Ryan</i>                                                                                                                                                                                                                   |  |                                |  |                                                                                                 |  |                                                                                                       |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Paulette A. Michaels</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>401 N. Ridge Ave., York, PA 17403</i>                                                                                                                                                   |  |                                |  |                                                                                                 |  |                                                                                                       |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |                                                  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Yorktowne Crematory 11/29/95</i>                                                                                                                                                                      |  |                                |  | 20c. LOCATION — City or Town, State<br><i>York, PA</i>                                          |  |                                                                                                       |  |                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John T. Semmel - Supervisor</i>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><i>Workinger-Semmel Funeral Home, Inc.<br/>849 East Market Street, York, PA 17403</i>                                                                                                                                                                   |  |                                |  |                                                                                                 |  |                                                                                                       |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Renal Failure</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Liver Failure</i><br><i>Squamous Cell Carcinoma</i> |  |                                                                                                                                              |                                                  |                                                                                                                                                                                                                                                                                             |  |                                |  |                                                                                                 |  | Approximate interval Between Onset and Death<br><i>1 month</i><br><i>1 month</i><br><i>2 years</i>    |  |                                                                                                                                                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |                                                  |                                                                                                                                                                                                                                                                                             |  |                                |  |                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |                                                  |                                                                                                                                                                                                                                                                                             |  |                                |  |                                                                                                 |  |                                                                                                       |  |                                                                                                                                                    |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |                                                  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                |  |                                                                                                 |  |                                                                                                       |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                 |  |                                                                                                                                              |                                                  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br>M       |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURED                                                                      |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |                                                  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  |                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |                                                                                                       |  |                                                                                                                                                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                               |  |                                                                                                                                              |                                                  |                                                                                                                                                                                                                                                                                             |  |                                |  |                                                                                                 |  |                                                                                                       |  |                                                                                                                                                    |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mitchell G. Ceph</i> MD                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |                                                  | 29c. LICENSE NUMBER<br><i>07967</i>                                                                                                                                                                                                                                                         |  |                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>November 24, 1995</i>                                 |  |                                                                                                       |  |                                                                                                                                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Mitchell A. Ceph University of Maryland Medical System, Baltimore, MD</i>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |                                                  |                                                                                                                                                                                                                                                                                             |  |                                |  |                                                                                                 |  |                                                                                                       |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 30 1995</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |                                                  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Davidson</i>                                                                                                                                                                                                                                        |  |                                |  |                                                                                                 |  |                                                                                                       |  |                                                                                                                                                    |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                  |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>RICHARD VINCENT RICHARDSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>27</b> YEAR <b>1995</b>                                                                                                                                                                                                                    |  | 3. TIME OF DEATH<br><b>6:14 p.m.</b>                                             |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>122-32-5248</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                   |  | 6. AGE (in yrs. last birthday)<br><b>52</b> 53 YRS.                                                                                                                                                                                                                                         |  | 7. DATE OF BIRTH<br>MONTH <b>Nov</b> DAY <b>06</b> YEAR <b>1942</b>              |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>                                           |  |                                                                                                                                         |  |                                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Union Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                     |  |                                                                                  |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                     |  |                                                                                                                                         |  |                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br><b>Perry Hall</b>                                 |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |                                                                                                                                         |  |                                                                 |  |
| 10e. STREET AND NUMBER<br><b>3455 Santee Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | 10f. ZIP CODE<br><b>21236</b>                                                                                                                                                                                                                                                               |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                            |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                             |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 years</b> College (1-4 or 5+) <b>2 years</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Self employed</b>                                                                                                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Sales</b>                                   |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Richard Francis Richardson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Florence Octavia Brown</b>                                                                                                                                                                                                          |  |                                                                                  |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Jean R. Richardson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3455 Santee Road Baltimore, Maryland 21236</b>                                                                                                                                          |  |                                                                                  |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corporation 12-1</b>                   |  | OATE                                                                                                                                                                                                                                                                                        |  | 20c. LOCATION — City or Town, State<br><b>Towson, Maryland</b>                   |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Scott P. Gardner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck, Inc.<br/>5305 Harford Road Baltimore, Md. 21214</b>                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>b. Atherosclerotic Coronary Heart Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>c. Hypercholesterolemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>d.</b> |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                  |  | Approximate Interval Between Onset and Death<br><b>Immediate</b><br><b>9 1/2 years</b>                |  |                                                                                                                                         |  |                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypercholesterolemia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                  |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                  |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                       |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                             |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                     |  |                                                                                                                                         |  |                                                                 |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |  |                                                                                  |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Henry J. Babitt, M.D.</b>                                 |  | 29c. LICENSE NUMBER<br><b>D00337</b>                                                                                                    |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 28, 1995</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Henry Babitt G.B.M.C. Towson, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                  |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><b>J. A. Anderson-Randall</b>                                                                                                                                                                                                                                  |  |                                                                                  |  |                                                                                                       |  |                                                                                                                                         |  |                                                                 |  |



95 36328

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CONCETTA ANNA RESTIVO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 27, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>2:55 A.M.</b>                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-44-8390</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Mar 16 1901</b>                                                                               |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>8206 Loch Raven Blvd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Loch Raven</b>                                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                 |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Loch Raven</b>                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><b>8206 Loch Raven Blvd</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21286</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                 |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>                                                                                                                                               |  |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Vizzini</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marie (Not Known)</b>                                                                                                                   |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patricia A. Oxnard</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1412 Putty Hill Rd. Baltimore, Md. 21286</b>                                                |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>New Cathedral Cem. 11/30/95</b>                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Maryland</b>                                                                                                                                |  |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Milton Knight Jr</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J Ruck, Inc.<br/>5305 Harford Rd. Baltimore, Md. 21214</b>                                                                                       |  |                                                                                                                                         |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Aortic Stenosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | Approximate Interval Between Onset and Death<br><b>2</b><br><b>&gt;5yrs</b>                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HASCD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 29. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> 1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Richard Maffezzoli</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>207132</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/27/95</b>                                                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Richard Maffezzoli, 515 Fairmount Ave. Towson, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 95 36329

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           |                                                                                                                                                                                               |                                                                                      |                                                                  |                                                                                                                                                        |                                                                                                                                                                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br>Harold Verdell Sims, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           | 2. Date of Death<br>Month Day Year<br>November 29, 1995                                                                                                                                       |                                                                                      | 3. Time of Death<br>2:25 P.M.                                    |                                                                                                                                                        |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br>1127 Beall Place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           | 4b. City, Town, or Location of Death<br>Laurel                                                                                                                                                |                                                                                      | 4c. County of Death<br>Prince George                             |                                                                                                                                                        |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br>489-16-3842                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                             | 7. Age (In yrs. last birthday)<br>75 Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                                | If Under 24 Hrs.<br>Hours Min.                                                       | 8. Date of Birth (Month, Day, Year)<br>DEC. 11, 1919             | 9. Birthplace (State or Foreign Country)<br>Missouri                                                                                                   |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           |                                                                                                                                                                                               |                                                                                      |                                                                  |                                                                                                                                                        |                                                                                                                                                                                                          |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                 | 10b. County<br>Prince George                                                                                                                           |                                           | 10c. City, Town or Location<br>Laurel                                                                                                                                                         |                                                                                      |                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                         |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br>1127 Beall Place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           | 10f. Zip Code<br>20707                                                                                                                                                                        |                                                                                      | 10g. Citizen of What Country?<br>USA                             |                                                                                                                                                        |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII<br>If Yes, Give Year or Dates: |                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                                                                        |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Computer Division Chief                                                          |                                                                                      | 18b. Kind of Business/Industry<br>US Government                  |                                                                                                                                                        |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 17. Father's Name (First, Middle, Last)<br>Sollie V. Sims                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br>Clara Alexander                                                                                                                          |                                                                                      |                                                                  |                                                                                                                                                        |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 19a. Informant's Name/Relationship (Type, Print)<br>Katherine S. Sims/ Wife                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1127 Beall Place, Laurel, Maryland 20707                                                     |                                                                                      |                                                                  |                                                                                                                                                        |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington National Cem.                                                      |                                           | Date<br>12/8/95                                                                                                                                                                               |                                                                                      | 20c. Location - City or Town, State<br>Arlington, Virginia       |                                                                                                                                                        |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           | 22. Name and Address of Facility<br>Fleck Funeral Home, Inc.<br>7601 Sandy Spring Road, Laurel, Maryland 20707                                                                                |                                                                                      |                                                                  |                                                                                                                                                        |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23a. Part I. Enter the disease, or complications immediately preceding death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Pancreatic Mass</u><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           |                                                                                                                                                                                               |                                                                                      |                                                                  |                                                                                                                                                        | Approximate Interval Between Onset and Death<br>3 mos                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           |                                                                                                                                                                                               |                                                                                      |                                                                  |                                                                                                                                                        | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           |                                                                                                                                                                                               |                                                                                      |                                                                  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                              |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           |                                                                                                                                                                                               |                                                                                      |                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                                                                                                                          |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                                                                                                                                        |                                           |                                                                                                                                                                                               |                                                                                      |                                                                  |                                                                                                                                                        |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                           |                                                                                                                                                        | 28b. Time of Injury<br>M                  |                                                                                                                                                                                               | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                                                                      |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                          |                                                                                                                                                        |                                           |                                                                                                                                                                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                                                  |                                                                                                                                                        |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           |                                                                                                                                                                                               |                                                                                      |                                                                  |                                                                                                                                                        |                                                                                                                                                                                                          |  |
| 29b. Signature and Title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        | 29c. License number<br>42832 (MS)         |                                                                                                                                                                                               | 29d. Date signed (Month, Day, Year)<br>11/30/95                                      |                                                                  |                                                                                                                                                        |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>G.D. Denton Bethesda Naval Hospital 8901 Wisconsin Ave. Bethesda, MD                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        |                                           |                                                                                                                                                                                               |                                                                                      |                                                                  |                                                                                                                                                        |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                   |                                                                                                                                                        |                                           |                                                                                                                                                                                               |                                                                                      |                                                                  |                                                                                                                                                        |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

1 - FOR  
STATE  
REGISTRAR

REG. NO.

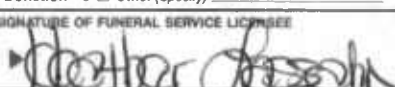
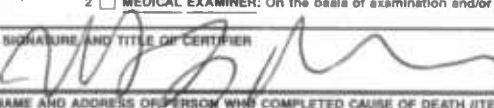

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                        |                                                  |                                                                                                                                                                                     |  |                                                                              |  |                                                                         |  |                                                                 |  |                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ronald L. Stansbury</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                        |                                                  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 29, 1995</b>                                                                                                                      |  |                                                                              |  | 3. TIME OF DEATH<br><b>1:06am</b>                                       |  |                                                                 |  |                                                                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-34-0256</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><b>1</b> M <b>2</b> F                                                                                        | 6. AGE (In yrs. last birthday)<br><b>57</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                      |  | IF UNDER 24 HRS.<br>HOURS MIN.                                               |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 9, 1938</b>           |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>     |  |                                                                                                         |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harbor Hospital Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                        |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                                                                                                                        |  |                                                                              |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                       |  |                                                                 |  |                                                                                                         |  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>Anne-Arundel</b>                                                                                     |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>                                                                                                                                   |  |                                                                              |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO                    |  |                                                                 |  |                                                                                                         |  |
| 10e. STREET AND NUMBER<br><b>6433 Continental Drive</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                        |                                                  | 10f. ZIP CODE<br><b>21061</b>                                                                                                                                                       |  |                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                   |  |                                                                 |  |                                                                                                         |  |
| 11. MARITAL STATUS<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES                      |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> NO Specify:                                |  |                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |                                                                 |  |                                                                                                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b><br>College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                        |                                                  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Service Mechanic</b>                                            |  |                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>General Electric</b>               |  |                                                                 |  |                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Walter Stansbury</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                        |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Edna Hood</b>                                                                                                               |  |                                                                              |  |                                                                         |  |                                                                 |  |                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary V. Stansbury</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                        |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6433 Continental Drive, Glen Burnie, Maryland 21061</b>                         |  |                                                                              |  |                                                                         |  |                                                                 |  |                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery, December 1, 1995</b> |                                                  |                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><b>Maryland</b>                       |  |                                                                         |  |                                                                 |  |                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                        |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>Charles L. Stevens Funeral Home, Inc.<br/>1501 E. Fort Avenue, Baltimore, Maryland 21230</b>                                                 |  |                                                                              |  |                                                                         |  |                                                                 |  |                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Atherosclerotic Cardiovascular Disease</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST {<br><b>b. Severe Coronary Artery Disease</b><br><b>c. Peripheral Vascular Disease</b><br><b>d. Diabetes mellitus</b> |  |                                                                                                                        |                                                  |                                                                                                                                                                                     |  |                                                                              |  |                                                                         |  | Approximate Interval Between Onset and Death<br><b>12 years</b> |  |                                                                                                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                        |                                                  |                                                                                                                                                                                     |  |                                                                              |  |                                                                         |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                        |                                                  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA<br>OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |                                                                              |  |                                                                         |  |                                                                 |  |                                                                                                         |  |
| 27. MANNER OF DEATH<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                              |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                     |  | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO                             |  | 28d. DESCRIBE HOW INJURY OCCURRED                                       |  |                                                                 |  |                                                                                                         |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                        |                                                  |                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |                                                                         |  |                                                                 |  |                                                                                                         |  |
| 29a. CERTIFIER<br><b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                    |  |                                                                                                                        |                                                  |                                                                                                                                                                                     |  |                                                                              |  |                                                                         |  |                                                                 |  |                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                        |                                                  |                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br><b>015440</b>                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/29/95</b>                  |  |                                                                 |  |                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Walter Stansbury, BALT, MD 21202</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                        |                                                  |                                                                                                                                                                                     |  |                                                                              |  |                                                                         |  |                                                                 |  |                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                        |                                                  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                     |  |                                                                              |  |                                                                         |  |                                                                 |  |                                                                                                         |  |



95 36331

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Wilbur WILLIAM SMITH</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |                                                  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>25</b> YEAR <b>1995</b>                                                                                                                            |                                | 3. TIME OF DEATH<br><b>4:05 p m</b>                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>482-16-4894</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                          | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                      | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>OCTOBER 31, 1923</b>                                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>OSKALOOSA, IOWA</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FRANKLIN SQUARE HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE COUNTY</b>                                                                                                                                      |                                | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>                                                      |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                                                                    |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                     |                                | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>5621 KNELL AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |                                                  | 10f. ZIP CODE<br><b>21206</b>                                                                                                                                                                       |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                         |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>                                                                                                                                        |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |                                                  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>TOWER OPERATOR</b>                                                                 |                                | 16b. KIND OF BUSINESS/INDUSTRY<br><b>B &amp; O RAILROAD</b>                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>AUGUST SMITH</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MABEL FRY</b>                                                                                                                               |                                |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ANNA W. SMITH</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5621 KNELL AVENUE BALTIMORE, MARYLAND 21206</b>                                                 |                                |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place)<br><b>DULANEY VALLEY MEM. GDNS. NOVEMBER 28, 1995</b>                                                                                                                                                                |                                                  | 20c. LOCATION — City or Town, State<br><b>TIMONIUM, MARYLAND</b>                                                                                                                                    |                                |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>LASSAN FUNERAL HOME, INC.<br/>7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625</b>                                                                            |                                |                                                                                                     |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  | a. <u>Acute Myocardial Infarction</u><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                               |                                                  |                                                                                                                                                                                                     |                                | Approximate Interval Between Onset and Death<br><b>1 Hour</b>                                       |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  | b. <u>Coronary Artery Disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                                                     |                                | 20 Years                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | c. <u>Hypertension</u><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                              |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | d. _____                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |                                                  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                         |                                |                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                       |                                                  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |                                | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |                                                  | 29c. LICENSE NUMBER<br><b>D27315</b>                                                                                                                                                                |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-25-95</b>                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><b>M.L. Frydenborg MD. 9000 Franklin Square Dr. Balto, Md. 21237</b>                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                        |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36333

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN A. SCHRENK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>27</b> YEAR <b>95</b>                                                                                                                                                                                                                                                                                                                                                               |  | 3. TIME OF DEATH<br><b>4:30 P M</b>                                                                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-07-1354</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                 |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JUN 13, 1920</b>                                                                                                                             |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                      |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                        |  |
| 10c. CITY, TOWN OR LOCATION<br><b>WOODLAWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>7203 BARLOW COURT</b>                                                                                                                                     |  |
| 10f. ZIP CODE<br><b>21244</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SECURITY</b>                                                                                                                                                                                                                                                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>LIQUOR MANUFACTURING</b>                                                                                                                          |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN CECIL SCHRENK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ANNA T. SCHOEFIELD</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>TIMOTHY W. SCHRENK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7203 BARLOW CT., WOODLAWN, MD 21244</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LAKEVIEW MEMORIAL PARK 12-2 SYKESVILLE, MARYLAND</b>                                                                                                                                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Phillips Stacks</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STERLING ASHTON FUNERAL HOME, INC.<br/>736 EDMONDSON AVE., BALT., MD 21228</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal failure</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>prostate cancer (metastatic)</b><br>b. <b></b><br>c. <b></b><br>d. <b></b> |  |                                                                                |  | Approximate Interval Between Onset and Death<br><b>2 months</b><br><b>3 years -</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                         |  |                                                                                |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                            |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                            |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b></b>                                                                                                                                                                                                                                                                                                                                                                                |  | 28b. TIME OF INJURY<br>M <b></b>                                                                                                                                                       |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b></b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b></b>                                                                                      |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>H. Rackocka</i> , MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 29c. LICENSE NUMBER<br><b>D-45185</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 27 95</b>                                                                                                                               |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>H. RACKOCKA 800 CATON AVE, BALTO, MD 21228</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 3 0 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew...</i>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-6681-510

unk 95-275

asp

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILMG-729 11/30/95 t.t

95 36332

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KENNETH C. SAMUELS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                    |  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>02</b> YEAR <b>1995</b>                                                                                                                             |  | 3. TIME OF DEATH<br><b>1421</b> P M                                                             |                                                                                                                                                                                                                                                      |
| 4. SOCIAL SECURITY NUMBER<br><b>220-74-2856</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                         |  | 6. AGE (In yrs. last birthday)<br><b>32</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>2-13-63</b>                                        |                                                                                                                                                                                                                                                      |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>2764 TIVOLY AVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                    |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>N.A.</b>                                                              |                                                                                                                                                                                                                                                      |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                      |
| 10a. STATE<br><b>md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. COUNTY<br><b>N.A.</b>                                                                                                                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                                                                                                                                      |
| 10e. STREET AND NUMBER<br><b>1621 E. 31ST ST</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                    |  | 10f. ZIP CODE<br><b>21318</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |                                                                                                                                                                                                                                                      |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                       |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                         |                                                                                                                                                                                                                                                      |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b><br>College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Roofing</b>                                                                                                                                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Roofing BUSINESS</b>                                                                                                                                       |  |                                                                                                 |                                                                                                                                                                                                                                                      |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SAM SAMUELS Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                    |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY Booker</b>                                                                                                                         |  |                                                                                                 |                                                                                                                                                                                                                                                      |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY SAMUELS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                    |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1621 E. 31ST ST. BALTO-MD 21218</b>                                                         |  |                                                                                                 |                                                                                                                                                                                                                                                      |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DRUID RIDGE Cem</b>                                                                                                                                                                                                          |  | DATE<br><b>11/9</b>                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br><b>FR Heights - old court Rd</b>                         |                                                                                                                                                                                                                                                      |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph B. Locks, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                    |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Locks FUNERAL HOME 1304 N. Central Ave</b>                                                                                                               |  |                                                                                                 |                                                                                                                                                                                                                                                      |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. NARCOTIC INTOXICATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death                                                                                                                                                                                                         |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>VACANT HOUSE</b> |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                      |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br><b>UNKNOWN</b>                                                                                                                                                           |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. DESCRIBE NOW INJURY OCCURRED<br><b>SUBJECT INGESTED DRUGS</b>                                                                                                                                                                                                                                                 |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>UNKNOWN</b>                                                                                        |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>UNKNOWN</b>  |                                                                                                                                                                                                                                                      |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                      |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mario F. Golik Jr MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                    |  | 29c. LICENSE NUMBER<br><b>O.C.M.E</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 03, 1995</b>                                      |                                                                                                                                                                                                                                                      |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARIO F. GOLIK JR MD 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                      |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 3 0 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson Randall</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                      |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36334

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARION SCHENKER</b>                                                                                                                                                                                                                        |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 23, 1995</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 3. TIME OF DEATH<br><b>11:05 P M</b>                                                                                                                                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>223-30-2188-A</b>                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                 |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 3, 1928</b>                                                                                                                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington, DC</b>                                                                                                                                                                                                                         |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian Health Care Center</b>                                                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>                                                                                                                            |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                                                                                                                                                                                                                  |  |                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                       |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>                                                                                                                                                                                                                                       |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>11215 Oak Leaf Drive, Apt. 510</b>                                                                                                                        |  |
| 10f. ZIP CODE<br><b>20901</b>                                                                                                                                                                                                                                                             |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                          |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                                                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Yrs</b> College (1-4 or 5+) <b>Sales Person</b>                                                                                                                                      |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retail-Sales</b>                                                                                                                                                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Hyman Gordon</b>                                                                                                                                                                                                                            |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ida Slimowitz</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Norman L. Schenker</b>                                                                                                                                                                                                                           |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11215 Oak Leaf Drive, Apt. 510<br/>Silver Spring, Maryland 20901</b>                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                           |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Lebanon Cemetery</b>                                                                                                                                                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br><b>Adelphi, Maryland</b>                                                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald C. Stottmeyer</b>                                                                                                                                                                                                                  |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.<br/>232 CARROLL ST, NW, WASHINGTON, DC 20012</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                 |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIORESPIRATORY ARREST</b>                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| a. DUE TO (OR AS A CONSEQUENCE OF): <b>END STAGE RENAL DISEASE</b>                                                                                                                                                                                                                        |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| b. DUE TO (OR AS A CONSEQUENCE OF): <b>ISCHEMIC PERIPHERAL VASCULAR DISEASE</b>                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| c. DUE TO (OR AS A CONSEQUENCE OF): <b>INSULIN DEPENDENT DIABETES MELLITUS</b>                                                                                                                                                                                                            |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                       |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SAME AS ABOVE</b>                                                                                                                                            |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                 |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                    |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                       |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                     |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY                                                                                                                                                                    |  |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                              |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                              |  |                                                                                |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Farzad Assar / M.D.</b>                                                                                                                    |  |
| 29c. LICENSE NUMBER<br><b>D-40201</b>                                                                                                                                                                                                                                                     |  |                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-24-95</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FARZAD ASSAR, M.D. / 1502 S. MAIN ST., MT AIRY, MD 21771</b>                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                   |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. Hester</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

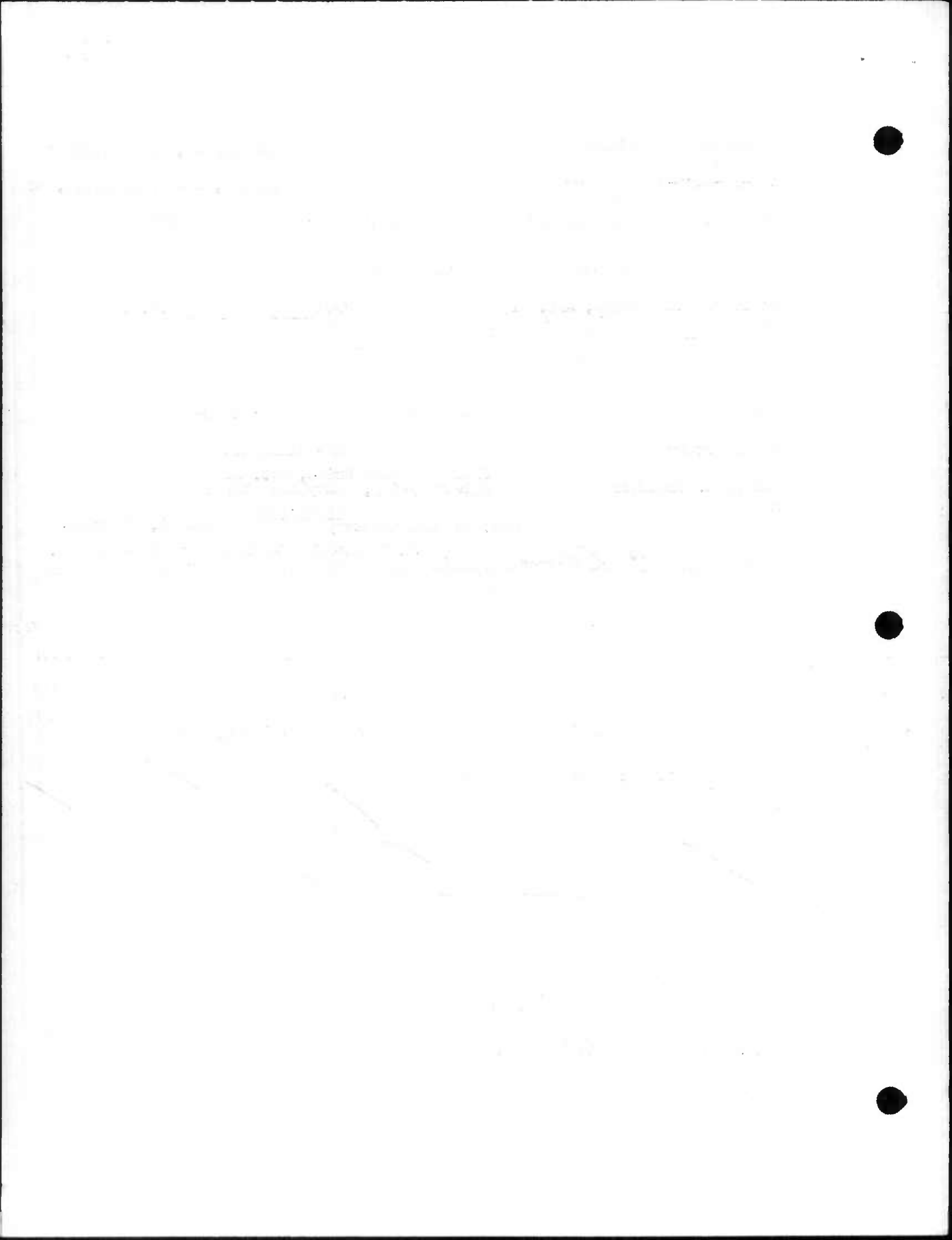
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36335

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                             |                                                                                                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LAURA SEPHUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 26 1995                                                                                                                                                  |  |                                                                                                 |                                                                             | 3. TIME OF DEATH<br>8:15 am M                                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br>112-03-1090                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br>91 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sept. 9, 1904                                         |                                                                             | 8. BIRTHPLACE (State or Foreign Country)<br>Virginia                                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Global Health Care Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                                                                                                                                    |  |                                                                                                 |                                                                             | 9c. COUNTY OF DEATH<br>N/A                                                                                |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                             |                                                                                                           |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br>N/A                                                                                                                                                                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                            |  |                                                                                                 |                                                                             | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br>1754 E. Preston St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  | 10f. ZIP CODE<br>21213                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                            |                                                                             |                                                                                                           |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                     |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |                                                                                                 | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Afro-American |                                                                                                           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                                                                          |  |                                                                                                 | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home                                  |                                                                                                           |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>James Berry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lucy Ann Berry                                                                                                                                 |  |                                                                                                 |                                                                             |                                                                                                           |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Zanes Cypress                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7 N. Kossuth St. Balto. Md. 21229                                                                  |  |                                                                                                 |                                                                             |                                                                                                           |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place)<br>Mt. Calvary 11/30/95                                                                                         |  |                                                                                                 | 20c. LOCATION — City or Town, State<br>Brooklyn, Md.                        |                                                                                                           |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Joseph L. Russ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  | 22. NAME AND ADDRESS OF FACILITY<br>Joseph L. Russ Funeral Home<br>2222 W. North Ave. Balto. Md. 21216                                                                                              |  |                                                                                                 |                                                                             |                                                                                                           |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>CONGESTIVE HEART FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>CORONARY ARTERY DIS<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                             | Approximate Interval Between Onset and Death                                                              |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>PNEUMONIA<br>OLD CVA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                             |                                                                                                           |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                             |                                                                                                           |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                             |                                                                                                           |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined                                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                               |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                             | 28d. DESCRIBE HOW INJURY OCCURRED                                                                         |  |
| 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                 |                                                                             |                                                                                                           |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                             |                                                                                                           |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br>108344                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/27/95                                                 |                                                                             |                                                                                                           |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Luis E. Rivera 5714 Harford Rd. Balto. Md. 21214                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                             |                                                                                                           |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                                                                            |  |                                                                                                 |                                                                             |                                                                                                           |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36336

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MYRON S. SEWELL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |                                                  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 24 1995</b>                                                                                                                                           |                                | 3. TIME OF DEATH<br><b>4:00 A M</b>                                                                 |                                                                                                           |                                                                                                                                                        |
| 4. SOCIAL SECURITY NUMBER<br><b>220-78-3794</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                          | 6. AGE (In yrs. last birthday)<br><b>37</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                      | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>4 14 1958</b>                                          |                                                                                                           |                                                                                                                                                        |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>SETON MANOR NURSING HOME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                             |                                | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                             |                                                                                                           |                                                                                                                                                        |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>                                                                                                                                                                                                                                                                      |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>SEVERN</b>                                                                                                                                                        |                                | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                           |                                                                                                                                                        |
| 10e. STREET AND NUMBER<br><b>8314 DEERFIELD CIRCLE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |                                                  | 10f. ZIP CODE<br><b>21144</b>                                                                                                                                                                       |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                         |                                                                                                           |                                                                                                                                                        |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                             |                                                                                                           |                                                                                                                                                        |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SUPERVISOR</b>                                                                                                                                                                      |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>F.B.I.</b>                                                                                                                                                     |                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM SEWELL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HAZEL SEWELL</b>                                                                                                                            |                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>HAZEL SEWELL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8314 DEERFIELD CIRCLE SEVERN, MARYLAND 21144</b>                                                |                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place)<br><b>SAINT REST CEMETERY 11/29/95</b>                                                                                                                                                                               |                                                  | DATE<br><b>11/29/95</b>                                                                                                                                                                             |                                | 20c. LOCATION — City or Town, State<br><b>HARMON, MARYLAND</b>                                      |                                                                                                           |                                                                                                                                                        |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leal A. Estep</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>ESTEP BROTHERS FUNERAL HOME PA.<br/>1300 EUTAW PLACE BALTIMORE, MARYLAND 21217</b>                                                                           |                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>END STAGE AIDS</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">         a. DUE TO (OR AS A CONSEQUENCE OF):<br/> <b>DIABETES MELLITUS</b><br/>         b. DUE TO (OR AS A CONSEQUENCE OF):<br/>         c. DUE TO (OR AS A CONSEQUENCE OF):<br/>         d.       </div> <div style="width: 35%; text-align: center;">         Approximate Interval Between Onset and Death       </div> </div> |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                           |                                                                                                                                                        |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                                  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edward Obazee MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                                  | 29c. LICENSE NUMBER<br><b>41430</b>                                                                                                                                                                 |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 24TH 1995</b>                                         |                                                                                                           |                                                                                                                                                        |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>EDWARD OBAAZEE MD 821 NORTH EUTAW ST #407 BALTIMORE 21221</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |                                                  |                                                                                                                                                                                                     |                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |                                                  | 32. REGISTRAR'S SIGNATURE<br><i>John Hudson</i>                                                                                                                                                     |                                |                                                                                                     |                                                                                                           |                                                                                                                                                        |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36337

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELLA SHARBS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>21</b> YEAR <b>1995</b>                                                                                                                             |  | 3. TIME OF DEATH<br><b>6:25 A</b> M                                                                                                                                            |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>219-26-2023</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8 5 1910</b>                                                                                                                      |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>FOREST HAVEN NURSING HOME</b>                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CATONSVILLE</b>                                                                                                                      |                                                                                                       |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                   |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                |                                                                                                       |
| 10c. CITY, TOWN OR LOCATION<br><b>ESSEX</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>4 GLEN SHANON COURT</b>                                                                                                                           |                                                                                                       |
| 10f. ZIP CODE<br><b>21221</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                     |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |                                                                                                       |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                                                                                        |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOME</b>                                                                                                                                  |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CORRIA HAWKINS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARTHA HAWKINS</b>                                                                                                                      |  |                                                                                                                                                                                |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>SHARON SHARBS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4 GLEN SHANON COURT ESSEX, MARYLAND 21221</b>                                               |  |                                                                                                                                                                                |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GAINES A.M.E. CHURCH CEM. 11/25/95</b>                                                                    |  | 20c. LOCATION — City or Town, State<br><b>ELKRIDGE, MARYLAND</b>                                                                                                               |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Carl A. Estep</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ESTEP BROTHERS FUNERAL HOME PA.<br/>1300 EUTAW PLACE BALTIMORE, MARYLAND 21217</b>                                                                       |  |                                                                                                                                                                                |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cerebral Thrombosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                | Approximate interval between Onset and Death<br><b>12 months</b>                                      |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                    |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                   |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Deborah I. Pierce DO</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D45931</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 21, 1995</b>                                                                                                                |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DEBORAH I. PIERCE 315 INGLESIDE AVENUE CATONSVILLE, MARYLAND 21228</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia...</i>                                                                                                                                                    |  |                                                                                                                                                                                |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.








95 36338

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Albert Clinton Stratmeyer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>28</b> YEAR <b>1995</b>                                                                                                                        |  | 3. TIME OF DEATH<br><b>6:00 a.m.</b>                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-09-2708</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept 20 1918</b>                                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>5070 Wright Avenue</b>                                                                                                      |  |                                                                                                 |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 11. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                               |  |                                                                                                 |  |
| 12. RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 13. CITY, TOWN OR LOCATION                                                                                                                                                                      |  |                                                                                                 |  |
| 14a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 14b. COUNTY<br><b>N/A</b>                                                                                                                                                                                                                                                                      |  | 14c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>                                                                                                                                            |  | 14d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 15. STREET AND NUMBER<br><b>5070 Wright Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 16. ZIP CODE<br><b>21205</b>                                                                                                                                                                    |  | 17. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                            |  |
| 18. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>                                                                                                                                   |  | 20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 21. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 22. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Serviceman</b>                                                                                                                                                                 |  | 24. KIND OF BUSINESS/INDUSTRY<br><b>Sears Retail Service</b>                                                                                                                                    |  |                                                                                                 |  |
| 25. FATHER'S NAME (First, Middle, Last)<br><b>John R. Stratmeyer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 26. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mollie Kellner</b>                                                                                                                      |  |                                                                                                 |  |
| 27. INFORMANT'S NAME (Type/Print)<br><b>Kathryn E. Stratmeyer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5070 Wright Ave. Baltimore, Md. 21205</b>                                                    |  |                                                                                                 |  |
| 29. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                   |  | 30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Redeemer Cem. 12/1/95</b>                                                                                                                                                                            |  | 31. LOCATION — City or Town, State<br><b>Baltimore Maryland</b>                                                                                                                                 |  |                                                                                                 |  |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><br><b>Milton J. Knight Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 33. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck, Inc.<br/>5305 Harford Rd. Baltimore, Md. 21214</b>                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDIAL INFARCTION, ACUTE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>A.S.C.V.D.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>3 MINUTES</b><br><b>20 YEARS</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 36. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 37. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 38. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                          |  | 39. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                          |  | 40. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N                                                                                        |  | 41. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO      |  |
| 42. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 43. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                           |  |                                                                                                 |  |
| 44. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 45. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 46. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Frank S. Palmisano Jr., M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 47. LICENSE NUMBER<br><b>D09475</b>                                                                                                                                                             |  | 48. DATE SIGNED (Month, Day, Year)<br><b>11-28-95</b>                                           |  |
| 49. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Frank S. Palmisano Jr., M.D. 5122 Harford Rd. Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 50. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 51. REGISTRAR'S SIGNATURE<br>                                                                                |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS: 23 PART I, 27, PER MEO FILM G-731 1/18/96 t.t

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                     |  |                                                                                                       |  |                                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>RICHARD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 26, 1995                                                                                                                                                                                                                                        |  |                                                                     |  | 3. TIME OF DEATH<br>1:30 P.M.                                                                         |  |                                                                                                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br>218-86-4391                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br>25 YRS.                                                                                                                                                                                                                                                      |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>JUNE 12, 1970             |  | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND                                                  |  |                                                                                                                                         |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>NORTHWEST HOSPITAL CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>RANDALLSTOWN                                                                                                                                                                                                                                            |  |                                                                     |  | 9c. COUNTY OF DEATH<br>BALTIMORE                                                                      |  |                                                                                                                                         |  |
| 10a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 10b. COUNTY<br>N/A                                                                                                                                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE CITY                       |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |                                                                                                                                         |  |
| 10e. STREET AND NUMBER<br>1825 EDMAR ROAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  | 10f. ZIP CODE<br>21208                                                                                                                                                                                                                                                                         |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA.                               |  |                                                                                                       |  |                                                                                                                                         |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK |  |                                                                                                       |  |                                                                                                                                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10th GRADE                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>UNEMPLOYED                                                                                                                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br>N/A                               |  |                                                                                                       |  |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>VERNICE SIMMONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>VERNICE SIMMONS                                                                                                                                                                                                                           |  |                                                                     |  |                                                                                                       |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>VERNICE SIMMONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>26 EXETER STREET, BALTIMORE, MARYLAND 21202                                                                                                                                                   |  |                                                                     |  |                                                                                                       |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MT. ZION CEMETERY                                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br>12-01-95 BALTIMORE, MARYLAND |  |                                                                                                       |  |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.<br>1913 W. BALTIMORE ST., BALTIMORE, MD. 21223                                                                                                                                                                      |  |                                                                     |  |                                                                                                       |  |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEIZURE DISORDER<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                     |  | Approximate Interval Between Onset and Death                                                          |  |                                                                                                                                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                     |  |                                                                                                       |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br>M                                            |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                      |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  |                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                            |  |                                                                                                                                              |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                      |  |                                                                     |  | 29c. LICENSE NUMBER<br>O.C.M.E.                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>NOVEMBER 27, 1995                                                                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARIO F. GOLUE JR. MD 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                     |  |                                                                                                       |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                  |  |                                                                     |  |                                                                                                       |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The license requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 is marked, the medical examiner must be notified at once.



DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM 6729 11/30/95 t.t

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RICHARD WILKERSON JR.</b>                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                                             | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 8, 1995</b>                                                                                 |                                                                                                                                                                                               | 3. TIME OF DEATH<br><b>0438 A<sup>M</sup></b>                  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-60-8784</b>                                                                                                                                                                                                                                                                                                                                                                              | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>41</b> YRS.                                                                                                                                                                                                                                                            | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12/12/53</b>                                                                                        | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>                                                                                                                                         |                                                                |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>2200 BLOCK PRENTISS PLACE</b>                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                                             | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                  |                                                                                                                                                                                               | 9c. COUNTY OF DEATH<br><b>N.A.</b>                             |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                      | 10b. COUNTY<br><b>N.A.</b>                                                 | 10c. CITY, TOWN OR LOCATION<br><b>BALTO.</b>                                                                                                                                                                                                                                                                |                                                                                                                                               | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                               |                                                                |
| 10e. STREET AND NUMBER<br><b>1621 N. Bradford ST.</b>                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 10f. ZIP CODE<br><b>21213</b>                                                                                                                                                                                                                                                                               |                                                                                                                                               | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                |                                                                |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |                                                                            | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                |                                                                                                                                               | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                                                |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                        |                                                                            | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>clerk</b>                                                                                                                                                                                  |                                                                                                                                               | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Commercial Credit</b>                                                                                                                                    |                                                                |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Richard Wilkerson Jr.</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                                                                                                                                             | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Josephine Blanchard</b>                                                               |                                                                                                                                                                                               |                                                                |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Josephine Wilkerson</b>                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                             | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1621 N. BRADFORD ST. BALTO., MD 21213</b> |                                                                                                                                                                                               |                                                                |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |                                                                            | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>BALTO. Cemetery 11/14</b>                                                                                                                                                                                            |                                                                                                                                               | 20c. LOCATION — City or Town, State<br><b>BALTO. MD</b>                                                                                                                                       |                                                                |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph H. Locks Jr.</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                                                                                                                                             | 22. NAME AND ADDRESS OF FACILITY<br><b>Locks Funeral Home 1304 N. Central Ave</b>                                                             |                                                                                                                                                                                               |                                                                |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>NARCOTIC INTOXICATION</b>                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| a. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |                                                                            | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b> |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined                                                                                                                                                      |                                                                            | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11-8-95 FOUND</b>                                                                                                                                                                                                                                              |                                                                                                                                               | 28b. TIME OF INJURY<br><b>4:30 A<sup>M</sup></b>                                                                                                                                              |                                                                |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                  |                                                                            | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>SUBJECT INGESTED DRUGS</b>                                                                                                                                                                                                                                          |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND ON PORCH</b>                                                                                                                                                                                                                                                                                                              |                                                                            | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>2200 BLK. PRENTISS PLACE BALTIMORE, MD.</b>                                                                                                                                                                              |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                             | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                        |                                                                                                                                                                                               | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 8, 1995</b> |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARIO F. GOLUE JR MD 11 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                               |                                                                |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BONNIE Lynn WEIGAND</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 27 1995</b>                                                                                                                                   |  | 3. TIME OF DEATH<br><b>0650A<sup>M</sup></b>                                                                               |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-74-2044</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 6. AGE (In yrs. last birthday)<br><b>28</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>April 03, 1967</b>                                                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>GOOD SAMARITAN HOSPITAL E.R.</b>                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                               |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                   |  | 10b. COUNTY<br><b>N/A</b>                                                                                                  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>1709 Pin Oak Ave.</b>                                                                         |  |
| 10f. ZIP CODE<br><b>21222</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                                                                                   |  |                                                                                                                            |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Steel Sales</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Steel Industry</b>                                                                                                                                         |  |                                                                                                                            |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Eugene Goldsbrough</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ingrid Anna Brey</b>                                                                                                                    |  |                                                                                                                            |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Ronay B. Weigand, Jr.</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3115 Clearview Ave. Baltimore, Maryland 21234</b>                                           |  |                                                                                                                            |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery Nov. 30, 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State<br><b>Parkville, Maryland</b>                                                                                                                               |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Jeffrey L. Gair</b><br><i>Jeffrey L. Gair</i>                              |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck, Inc.</b><br><b>5305 Harford Road Baltimore, Maryland 21214</b>                                                                                                                                                                                                                                                                                                       |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hanging</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                 |  |                                                                                                                            |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><i>inspection</i> |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO          |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                  |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                                            |  |
| 28a. DATE OF INJURY (Month, Day, Year)<br><b>Found 11/27/95</b>                                                                                                                                                                                                                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>0640 HR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                        |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject hanged self</b>                                                            |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>                                                                                                                                                                                                                                                                                                                        |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>1709 Pin Oak Road Towson Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                 |  |                                                                                                                            |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                                            |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Therese M. King</i>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 27, 1995</b>                                                            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Therese M. King 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                                            |  |
| 31. DATE OF DEATH<br><b>NOV 30 1995</b><br>REGISTRAR'S SIGNATURE<br><i>John A. ...</i>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                                            |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36343

ITEM: 3. PER MEO FILM G-729 11/30/95 t.t

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Daniel S. Winston</i>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                      |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>November 3, 1995</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 3. TIME OF DEATH<br>HOURS MINUTES AM/PM<br><i>10:30 A M</i>                                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><i>225-34-5656</i>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                       |  | 6. AGE (In yrs. last birthday)<br><i>61</i> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Dec. 25, 1933</i>                                                                              |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>VA</i>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                      |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>4408 Manorview Road</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>                                                                                     |  |
| 9c. COUNTY OF DEATH<br><i>N/A</i>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                      |  | 10a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br><i>N/A</i>                                                                                                                   |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10e. STREET AND NUMBER<br><i>4408 Manorview Road</i>                                                                                        |  |
| 10f. ZIP CODE<br><i>21229</i>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                      |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>KOREAN</i> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>                                                                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (0-12) 12TH</i><br><i>College (14 or 5+) 5c</i>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>ENGINEER</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>R.T.K. &amp; ASSOICATES</i>                                                                            |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>CARLTON WINSTON</i>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                      |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>MARTHA BOLLING</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>SHIRLEY WINSTON</i>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                      |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1164 E. NORTHERN PKWY BALTO, MD21239</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>in State</i>                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place)<br><i>GARRISON FOREST VET 11/20/95</i>                                            |  | 20c. LOCATION — City or Town, State<br><i>OWINGS MILLS, MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Specify March 11/25/95</i>                                                                  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><i>State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559</i>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                      |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac arrest</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><i>acute coronary thrombosis</i><br><i>arteriosclerotic cardiovascular disease</i><br><i>hypertension</i><br><i>diabetes mellitus</i> |  |                                                                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>hypertension</i><br><i>diabetes mellitus</i>                                                                                                                                                                                                                                                        |  |                                                                                                                                                                      |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                      |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                             |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  |                                                                                                                                                                      |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             |  |
| 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br><i>M</i>                                                                                                                                      |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                           |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                      |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                      |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Louis W. Miller MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><i>D07421</i>                                                                                                        |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><i>11-7-95</i>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                      |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Louis W. Miller MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 3 01995</i>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Karl</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36344

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                               |                                |                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY JANE YOUNG</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |                                                  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>25</b> YEAR <b>1995</b>                                                                                                                          |                                | 3. TIME OF DEATH<br><b>2:20 P M</b>                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-01-0153</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>FEB. 19, 1921</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SAINT AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                       |                                | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                               |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                               |                                |                                                                                                 |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>CATONSVILLE</b>                                                                                                                                             |                                | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>815 WINTERS LANE, APT. 126</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |                                                  | 10f. ZIP CODE<br><b>21228</b>                                                                                                                                                                 |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 8+) <b>12</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>CLERK</b>                                                                                                                                                                     |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FEDERAL GOVERNMENT</b>                                                                                                                                   |                                |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>L. HOLMES WHITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BARBARA M. ZIZZI</b>                                                                                                                  |                                |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>KATHERINE S. LETMATE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3264 NORMANDY WOODS DR., APT. C, ELLICOTT CITY, MD 21043</b>                              |                                |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>FORT LINCOLN CREMATORY 11/30/1995</b>                                                                                                                                                                    |                                                  | 20c. LOCATION — City or Town, State<br><b>BRENTWOOD, MARYLAND</b>                                                                                                                             |                                |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Theresa E. Fire</i> <b>MO0877</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>LOUDON PARK FUNERAL HOME, INC.<br/>3620 WILKENS AVENUE, BALTIMORE, MD 21229</b>                                                                        |                                |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE ON CHRONIC RENAL FAILURE</b><br>Approximate Interval Between Onset and Death <b>1 WEEK</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>CHRONIC RENAL FAILURE</b><br>Approximate Interval Between Onset and Death <b>5 YEARS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                               |                                |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                               |                                |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                               |                                |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                               |                                | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                                  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                             |                                |                                                                                                 |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |                                                  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |                                |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                               |                                |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Reewen C. D'Souza</i> <b>M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |                                                  | 29c. LICENSE NUMBER<br><b>D 76292</b>                                                                                                                                                         |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 29, 1995</b>                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>REEWEN C. D'SOUZA, DEPT. OF MEDICINE, ST. AGNES HOSPITAL, BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                               |                                |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |                                                  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>                                                                                                                                               |                                |                                                                                                 |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

12



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HAYWOOD YOUNG SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 19, 95</b>                                                                                                                                        |  | 3. TIME OF DEATH<br><b>4:24 PM</b>                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-78-5833</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                                                 |  | 6. AGE (In yrs. last birthday)<br><b>35 YRS.</b>                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JULY 11, 1960</b>                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>NORTH CAROLINA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1300 BLK. RIGGS AVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                               |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>                                            |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 10e. STREET AND NUMBER<br><b>4907 FREDERICK AVENUE, APT. E</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21229</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                                    |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                               |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN</b><br>College (1-4 or 5+) <b>LABORER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABORER</b>                                                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FACTORY</b>                                                                                                                                                    |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HAYWOOD (LN-UNKNOWN)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HELEN YOUNG</b>                                                                                                                             |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>SHARON YOUNG</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4907 FREDERICK AVENUE, BALTIMORE, MARYLAND 21229</b>                                            |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY 11-28-95</b>                                                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>                                                                                                                                   |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.<br/>1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</b>                                                                   |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>GUNSHOT WOUND OF HEAD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>VACANT HOUSE</b> |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>11/19/95</b>                                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br><b>UNKNOWN</b>                                                                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>SUBJECT SHOT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>VACANT HOUSE</b>                                                                                                                                                                                                                  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>1300 BLK RIGGS AVE, BALTIMORE MD</b>                                                                             |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 20, 1995</b>                                 |  |
| 30. NAME AND ADDRESS OF PHYSICIAN WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARGO F. GOLWÉ, JR. MD 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                       |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the death has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36346

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>NETTIE ZUSKIN</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 24, 1995</b>                                                                                                                                                                                                                                             |  | 3. TIME OF DEATH<br>HOURS MIN. SEC.<br><b>2:55 P M</b>                                                                                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-07-5067</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.                                                                                                                                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan. 24, 1917</b>                                                                                                                         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>11510 Taber Street</b>                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>                                                                                                                            |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                       |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                        |  | 10e. STREET AND NUMBER<br><b>11510 Taber Street</b>                                                                                                                                    |  |
| 10f. ZIP CODE<br><b>20902</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                             |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                                                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>12 Yrs</b> College (1-4 or 5+) <b>Housewife</b>                                                                                                                                                                                                                                                                             |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>                                                                                                                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Isaac Levy</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Fannie Finkelstein</b>                                                                                                                                                                                                                             |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Henry R. Zuskin</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11510 Taber Street<br/>Silver Spring, Maryland 20902</b>                                                                                                                                               |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>11/27/1995<br/>United Hebrew Cemetery</b>                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                      |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald C. Stottmeyer</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.<br/>232 CARROLL STREET, NW, WASHINGTON, DC 20012</b>                                                                                                                                                                       |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Inanition</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| b. <b>Adenocarcinoma Rectosigmoid</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Liver metastases - Ascites</b>                                                                                                                                                                                                                                                                      |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                         |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                           |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>William Kurstin MD</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 29c. LICENSE NUMBER<br><b>DC 820</b>                                                                                                                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/25/95</b>                                                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William Kurstin MD 1145 19th St NW WASH. DC</b>                                                                                                                                                                                                                                                                                        |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>11/25/95 NOV 30 1995</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

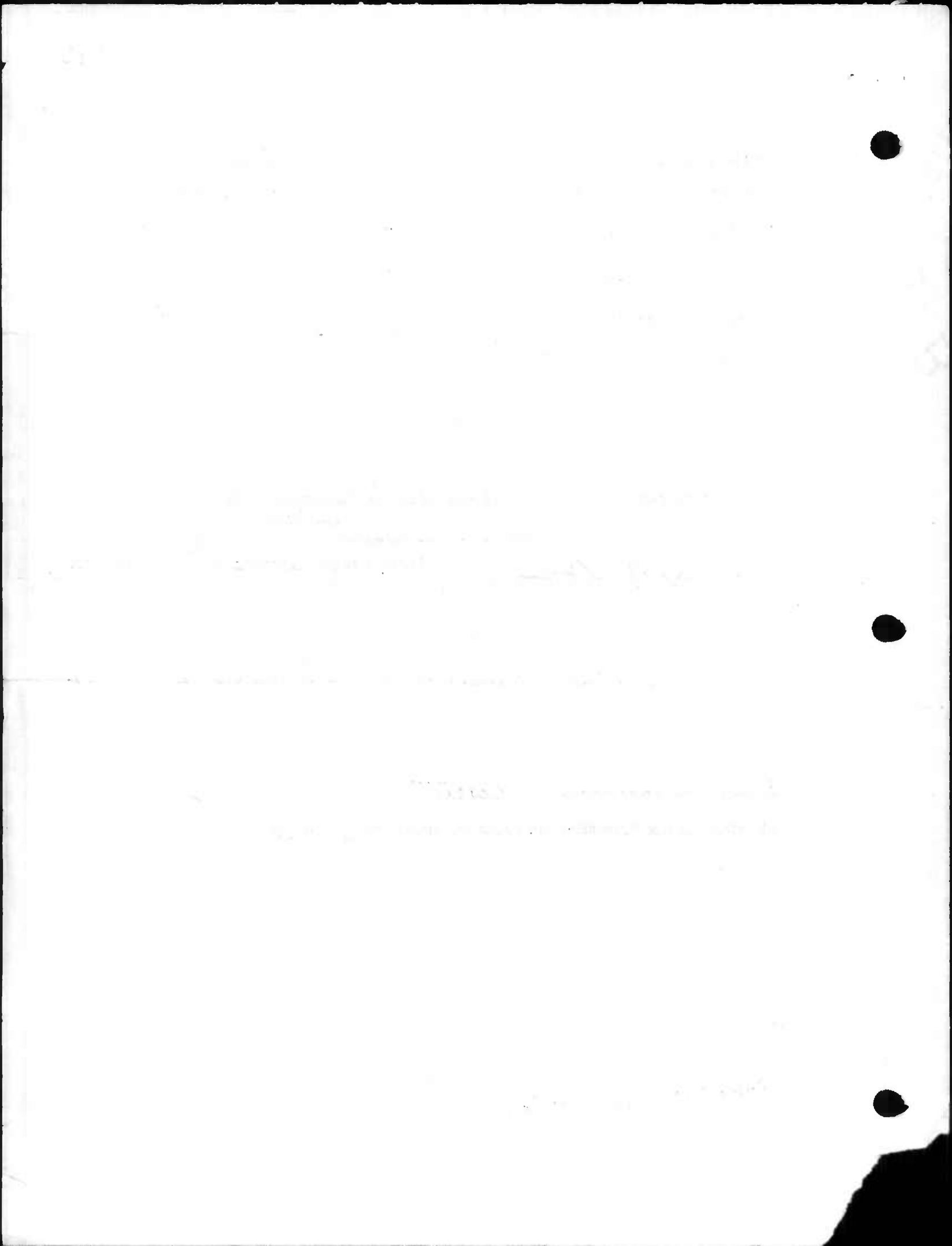
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36347

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>James P. Aubrey</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 25, 1995</b>                                                                                                                                                                                                                                     |  | 3. TIME OF DEATH<br><b>3:58 P.M.</b>                                                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220 24 7977</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>April 7, 1929</b>                                                                                                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>2155 Coralhorn Road</b>                                                                                                                                                                                                   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Middle River</b>                                                                                                                     |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Middle River</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>2155 Coralhorn Road</b>                                                                                                                           |  |
| 10f. ZIP CODE<br><b>21220</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                 |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1948-1952</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                                                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Lineman</b>                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Telephone Company</b>                                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James P. Aubrey Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruth C. Walters</b>                                                                                                                                                                                                                    |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marie B. Aubrey</b> <b>Wife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2155 Coralhorn Road Baltimore, Maryland 21220</b>                                                                                                                                          |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holly Hill Memorial Gardens 11/28/95 Middle River, Md.</b>                                                                                                                                               |  | 20c. LOCATION — City or Town, State                                                                                                                                            |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bruzdinski Funeral Home PA<br/>1407 Eastern Ave. Baltimore, Md. 21221</b>                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Small Cell Ca lung</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  | Approximate Interval Between Onset and Death<br><b>1 1/2 yr</b>                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                            |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                          |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)                                                                                         |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>D18487</b>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/27/95</b>                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MYO THANT 901 FRANKLIN SQUARE DRIVE, BALTO, MD 21237</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. December 1901

95 36348

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>TERESITA M APOLONIO</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>28</b> YEAR <b>95</b>                                                                                                                                                                                                                              |  | 3. TIME OF DEATH<br><b>11:09P</b>                                                                                                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br><b>586-72-2643</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>46</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb. 12 1949</b>                                                                                                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Philippines</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>University Hospital</b>                                                                                                                                                                                                   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                        |  |
| 9c. COUNTY OF DEATH<br><b>NA</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><b>NA</b>                                                                                                                                                       |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>E. Lombard Street 1721</b>                                                                                                                        |  |
| 10f. ZIP CODE<br><b>21231</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>Philippines</b>                                                                                                                                                                                                                                            |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Asian</b>                                                                                                        |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Owner - Manager</b>                                                                                                                                                        |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Appliance Store</b>                                                                                                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Leonardo Malabanan</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Incalvasia Javier</b>                                                                                                                                                                                                                  |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Felomino Sanitago Apolonio</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>E. Lombard St. 1721 Baltimore, Md. 21231</b>                                                                                                                                               |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>OAK LAWN December 2</b>                                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State<br><b>East Point, Maryland</b>                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Mark A. Chojnacki</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>W. Dabrowski &amp; Chojnacki, F.H.P.A.<br/>1005 Dundalk Ave. Balto., Md. 21224</b>                                                                                                                                                                      |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Breast Cancer</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                      |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal failure, Hepatic failure, Anasarca, Bacterial pneumonia<br/>Peritoneal and pleural effusions, obstructive jaundice</b>                                                                                                                                                                    |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                |  |                                                                            |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Spencer S. Markowitz, MD</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>P08677</b>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/29/95</b>                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SPENCER S. MARKOWITZ, MD UNIVERSITY OF MARYLAND CANCER CENTER</b>                                                                                                                                                                                                                                                                  |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. Buckner-Randall</b>                                                                                                                                                                                                                                    |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36349

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Richard William ARNDT                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 28, 1995                                                                                                                                             |  | 3. TIME OF DEATH<br>6:44 P M                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br>216-05-7065                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>77 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 22, 1918                              |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Franklin Square Hospital                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rosedale                                                                                                                                                     |  | 9c. COUNTY OF DEATH<br>Baltimore County                                              |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br>N/A                                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore City                                        |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 10e. STREET AND NUMBER<br>5413 Radecke Avenue                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21206                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                              |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8th Grade                                                                                                                                                                                                                                                                                                                   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Electrician                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Hospital                                                                                                                                                          |  |                                                                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Richard Bernard Arndt                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Adele Meta Habicht                                                                                                                             |  |                                                                                      |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Helen Rose Arndt                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5413 Radecke Avenue, Baltimore, Maryland 21206                                                     |  |                                                                                      |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Hilltop Service Corporation 11/30/95                                                                                                                                                                                    |  | 20c. LOCATION — City or Town, State<br>Towson, Maryland                                                                                                                                             |  |                                                                                      |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Kathleen M. Murphy                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>John C. Miller, Inc.<br>6415 Belair Road, Baltimore, Maryland 21206                                                                                             |  |                                                                                      |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary artery disease                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| b. Myocardial infarction                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| c. Severe dehydration                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| d. Septicemia                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| Approximate Interval Between Onset and Death<br>2 years<br>4 days<br>1 day                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Emphysema, Atherosclerosis                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                      |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Orn Eliasson, M.D.                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>D31076                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11-29-95                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Orn Eliasson, M.D. 9105 Franklin Square Drive Baltimore, MD 21237                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 31. DATE FILED (Month, Day, Year)<br>DEC 01 1995                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>John A. ...                                                                                                                                                            |  |                                                                                      |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36350

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                    |                                           |                                                                                                                                                                                        |  |                                                                                                     |                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>John Francis Beck                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                    |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 29, 1995                                                                                                                                |  | 3. TIME OF DEATH<br>2:15 P M                                                                        |                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br>218-02-8262                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br>83 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>July 10, 1912                                                                                                                                   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Baltimore, MD                                           |                                                                                                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br>748 Camberley Circle Apt. B5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                    |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson                                                                                                                                          |  | 9c. COUNTY OF DEATH<br>Baltimore                                                                    |                                                                                                                                             |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                           |                                           | 10c. CITY, TOWN OR LOCATION<br>Towson                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                             |
| 10e. STREET AND NUMBER<br>748 Camberley Circle Apt. B5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                    |                                           | 10f. ZIP CODE<br>21204                                                                                                                                                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                                      |                                                                                                                                             |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII                                                                                                                                                           |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |                                                                                                                                             |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Years<br>College (1-4 or 5+) College                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Clerk                                                                                                                                                                                                |                                           | 16b. KIND OF BUSINESS/INDUSTRY<br>U.S. Post Office                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br>Frank Beck                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                    |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Olympia Hauser                                                                                                                    |  |                                                                                                     |                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br>Jane F. Beck                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                    |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>748 Camberley Cir. Apt. B5 Towson, MD 21204                                           |  |                                                                                                     |                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenmount Crematory 11/30                                                                                                                                                                                                      |                                           | 20c. LOCATION — City or Town, State<br>Baltimore                                                                                                                                       |  |                                                                                                     |                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John O. Mitchell IV</i> MO1055                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                    |                                           | 22. NAME AND ADDRESS OF FACILITY<br>Mitchell-Wiedefeld Home, Inc.<br>6500 York Rd.<br>Baltimore, MD 21212                                                                              |  |                                                                                                     |                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic Prostate Cancer</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that inflamed events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                                    |                                           |                                                                                                                                                                                        |  |                                                                                                     | Approximate Interval Between Onset and Death                                                                                                |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Arteriosclerotic Cardiovascular Disease</u>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                    |                                           |                                                                                                                                                                                        |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                    |                                           |                                                                                                                                                                                        |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                        |  |                                                                                                     |                                                                                                                                             |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                             |                                           | 28b. TIME OF INJURY<br>M                                                                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                  |                                           | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                 |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                    |                                           |                                                                                                                                                                                        |  |                                                                                                     |                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edward Miller</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                    |                                           | 29c. LICENSE NUMBER<br>D9423                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/30/95                                                     |                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Edward Miller 5601 Loch Raven Blvd. Baltimore, MD 21239                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                    |                                           |                                                                                                                                                                                        |  |                                                                                                     |                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br>DEC 01 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                    |                                           | 32. REGISTRAR'S SIGNATURE<br><i>John A. Hurd</i>                                                                                                                                       |  |                                                                                                     |                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36351

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>THOMAS BRADFORD JR.                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV. 28, 1995                                                                                                                                             |  | 3. TIME OF DEATH<br>2:28 A M                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br>420-50-5328                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br>54 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>DEC. 21, 1940                                                                                                                                         |  | 8. BIRTHPLACE (State or Foreign Country)<br>BIRMINGHAM, AL.                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>UNIVERSITY HOSPITAL                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY                                                                                                                                           |  | 9c. COUNTY OF DEATH<br>n/a                                                                      |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br>n/a                                                                                                                                                                                                                                                                             |                                           | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE                                                                                                                                                        |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>4370 SHAMROCK AVENUE                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |                                           | 10f. ZIP CODE<br>21206                                                                                                                                                                          |  | 10g. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES                                                  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>7-8-58/4-19-60                                                                                                                              |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                                |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12 th -                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                           | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CHEF / FORKLIFTER                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br>HOTEL / LOCAL 557                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>THOMAS BRADFORD S R.                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>GLADYS BURROUGHS                                                                                                                           |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>ANN BRADFORD                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>723 N. PATTERSON PARK, BALTIMORE, MD 21205                                                     |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, temporary or other place)<br>GARRISON FOREST VAC EM. 12-4                                                                                                                                                                                |                                           | 20c. LOCATION — City or Town, State<br>OWINGS MILLS, MD                                                                                                                                         |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Helena Mahoney-Davis</i>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |                                           | 22. NAME AND ADDRESS OF FACILITY<br>WM. C. MARCH FH.-1101 E. M NORTH AV ENUE                                                                                                                    |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTI ORGAN FAILURE SYNDROME                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Due to (or as a consequence of): b. NECROTIZING FASCITIS ANTERIOR ABDOMINAL WALL                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Due to (or as a consequence of): c.                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Due to (or as a consequence of): d.                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>IDDM, HEPATITIS C, HEPATIC ENCEPHALOPATHY                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |                                           | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |                                           | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> M.D.                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                           | 29c. LICENSE NUMBER<br>D47685                                                                                                                                                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Nov 28, 1995                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>NAEEM A. LUGHMANI 22 S. GREEN ST. BALTO, MD 21201                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br>DEC 01 1995                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                           | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36352

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                       |  |                                                                                                                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>James E. Brown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 30 <sup>th</sup> 1995                                                                                                                                                                                                                                           |  |                                                                                       |  | 3. TIME OF DEATH<br>7:30 A.M.                                                                                                                          |  |
| 4. SOCIAL SECURITY NUMBER<br>216-36-9360                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br>53 YRS.                                                                                                                                                                                                                                                                  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>JUN. 12, 1942                               |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                                                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Union Memorial Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City                                                                                                                                                                                                                                                      |  |                                                                                       |  | 9c. COUNTY OF DEATH<br>N/A                                                                                                                             |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                       |  |                                                                                                                                                        |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br>N/A                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                                                                                                                                   |  |                                                                                       |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br>2128 N. Wolfe Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  | 10f. ZIP CODE<br>21213                                                                                                                                                                                                                                                                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                               |  |                                                                                                                                                        |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  |                                                                                       |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                                                                       |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) 11th<br>College (1-4 or 5+) —                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Baker                                                                                                                                                                                     |  |                                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Bakery                                                                                                               |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Danny Brown, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elizabeth Stern                                                                                                                                                                                                                                       |  |                                                                                       |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Elizabeth Brown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2128 N. Wolfe Street/Baltimore, MD 21213                                                                                                                                                                  |  |                                                                                       |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>BALTIMORE CEMETERY 12-4                                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MD                                  |  |                                                                                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Adeline E. Pienie</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br>March Funeral Home East<br>1101 E. North Avenue/Baltimore, MD 21202                                                                                                                                                                                                    |  |                                                                                       |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiopulmonary arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Acute Renal Failure / Metastatic CA</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Breast cancer Kidney Metastatic</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <i>Lung Cancer</i> |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                       |  | Approximate Interval Between Onset and Death<br>5 min<br>1 week<br>1 year<br>1 year                                                                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                       |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                       |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                       |  |                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  |                                                                                       |  |                                                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |  |                                                                                       |  |                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                       |  |                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Siddiqi M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 29c. LICENSE NUMBER<br>AT 2438946                                                                                                                                                                                                                                                                          |  |                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>Nov 30 <sup>th</sup> 1995                                                                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>NAHID F. SIDDIQI M.D., UMH DEPT. MED. BALTIMORE 21218                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                       |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>DEC 01 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><i>Juli Brundage</i>                                                                                                                                                                                                                                                          |  |                                                                                       |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

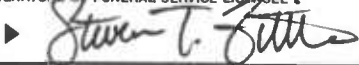


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36353

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Elizabeth Sisk Ullrich Browne</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>25</b> YEAR <b>1995</b>                                                                                                                                                                                                                                         |  | 3. TIME OF DEATH<br><b>5:23 a.m.</b>                                                                      |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-44-4897</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.                                                                                                                                                                                                                                                                 |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>January 19, 1913</b>                                            |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Roland Park Place</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                          |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                         |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                        |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>830 West 40th Street</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 10f. ZIP CODE<br><b>21211</b>                                                                                                                                                                                                                                                                                    |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                     |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) _____                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>                                                                                                                                                                                                                                                                |  |                                                                                                           |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Vincent Michael Sisk</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Ellen Noonan</b>                                                                                                                                                                                                                                    |  |                                                                                                           |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elizabeth Ullrich Slanker</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1851 Poplar Ridge Road Pasadena, Maryland 21122</b>                                                                                                                                                          |  |                                                                                                           |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____                                                                                                                                                                           |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenmount Crematory</b>                                   |  | OATE <b>11/27</b>                                                                                                                                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home, Inc.<br/>6500 York Road Baltimore, Maryland 21212</b>                                                                                                                                                                                            |  |                                                                                                           |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                       |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                               |  | a. <b>Alzheimer's Disease</b>                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                              |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                      |  | c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                              |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                              |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                 |  |                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br>M _____                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                             |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)                                                                                                                                                                                                                           |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |  |
| 29. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>D23074</b>                                                                                                                                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 25, 1995</b>                                           |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Richard L. Diamond, M.D. 3730 Falls Road Baltimore, Maryland 21211</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                 |  |                                                                                                           |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

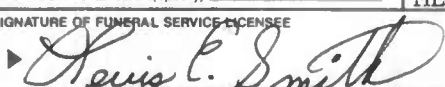
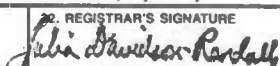
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FLOSSIE BELL BLOODSWORTH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>25</b> YEAR <b>1995</b>                                                                                                                                                                                                                                                                                                                                                           |  | 3. TIME OF DEATH<br><b>10:30 P M</b>                                                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-36-5227</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.                                                                                                                                                                                                                                                                                                                                                                             |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MARCH 5, 1917</b>                                                                                                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>CARROLL COUNTY GENERAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>WESTMINSTER</b>                                                                                                                      |  |
| 9c. COUNTY OF DEATH<br><b>CARROLL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                |  |
| 10c. CITY, TOWN OR LOCATION<br><b>ARBUTUS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>5551 GAYLAND ROAD</b>                                                                                                                             |  |
| 10f. ZIP CODE<br><b>21227</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                        |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>H/S GRAD</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>TELEPHONE</b>                                                                                                                                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>MONTGOMERY WARDS</b>                                                                                                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ADOLFUS WALTERS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>NELLIE HORNER</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. JUDITH BULL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5822 DALE DRIVE - ELDERSBURG, MD 21784</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MEADOWRIDGE MEMORIAL PARK 11/28 ELKRIDGE</b>                                                                                                                                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State                                                                                                                                            |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. lung failure</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. Severe COPD</b><br><b>c. Lung Cancer</b><br><b>d. Bladder Cancer</b> |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                     |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                       |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                              |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                         |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Lampley-Mills MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>D44462</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/25/95</b>                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NIL LANTÉ LAMPLEY-MILLS, CARROLL COUNTY HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item 28a, Film 730, 12/1/95, 1t

95 36354

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CLARENCE BROWN, JR.</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 23, 1995</b>                                                                                                                                  |  | 3. TIME OF DEATH<br><b>8:30 P M</b>                                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>230-12-1146</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 5, 1920</b>                                                                                                                     |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1300 Valley Street</b>                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                        |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                   |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                      |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>1804 Barclay Street</b>                                                                                                                           |  |
| 10f. ZIP CODE<br><b>21202</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Unknown - Navy</b>                                                                                                                                                                                                                                                        |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                        |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6 th</b><br>College (1-4 or 5+) <b>-</b>                                                                                                                                                                                                                                                                                   |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Baker</b>                                                                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Bakery</b>                                                                                                                                |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Clarence Brown, Sr.</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>unknown</b>                                                                                                                             |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Joann Brown</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1804 Barclay Street, Baltimore, MD 21202</b>                                                |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery 12-1</b>                                                                                |  | 20c. LOCATION — City or Town, State<br><b>Lansdowne, MD</b>                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Agnette K. Jones</i>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March Funeral Home East<br/>1101 E. North Avenue/Baltimore, MD 21202</b>                                                                                 |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARRHYTHMIA</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>HYPERTENSION</b>                                                                                                                                                                                                                                               |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>November 23, 1995</b>                                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>A. C. Dacan MD</i>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>m1639</b>                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>December 1, 1995</b>                                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ANNE D'KON, 110 TOWER, JOHNS HOPKINS HOSPITAL, BALTIMORE, MD 21287</b>                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                 |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36356

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>BETTY MAE BOWSER                                                                                                                                                                                                                           |  |                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 28, 1995                                                                                                                                                                                                                                                                                                                                                                             |  | 3. TIME OF DEATH<br>2:30 A M                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br>229-07-8024                                                                                                                                                                                                                                               |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                      |  | 6. AGE (In yrs. last birthday)<br>76 YRS.                                                                                                                                                                                                                                                                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>APRIL 1, 1919                              |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>VIRGINIA                                                                                                                                                                                                                                   |  |                                                                                                                                                     |  | 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL                                                                                                                                                                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY                                |  |
| 9c. COUNTY OF DEATH<br>N/A                                                                                                                                                                                                                                                             |  |                                                                                                                                                     |  | 10a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                      |  |
| 10b. COUNTY<br>N/A                                                                                                                                                                                                                                                                     |  |                                                                                                                                                     |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE CITY                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                      |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                    |  |                                                                                                                                                     |  | 10e. STREET AND NUMBER<br>1610 E. PRESTON STREET                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                      |  |
| 10f. ZIP CODE<br>21213                                                                                                                                                                                                                                                                 |  |                                                                                                                                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                      |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                 |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8TH College (1-4 or 5+) N/A                                                                                                                                                          |  |                                                                                                                                                     |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOUSEKEEPER                                                                                                                                                                                                                                                                                                        |  | 16b. KIND OF BUSINESS/INDUSTRY<br>JOHNS HOPKINS HOSPITAL                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>BURTON MCLAUGHLIN                                                                                                                                                                                                                           |  |                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>BETTY IRBY                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>JOAN BOWSER                                                                                                                                                                                                                                      |  |                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2625 BERYL AVE. BALTO, MD. 21205                                                                                                                                                                                                                                                                                                   |  |                                                                                      |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>BALTIMORE CEMETERY                                               |  | 20c. DATE<br>DEC. 4, 1995                                                                                                                                                                                                                                                                                                                                                                                                           |  | 20d. LOCATION — City or Town, State<br>BALTO, MD.                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Calvin B. Scruggs, Jr.</i>                                                                                                                                                                                                             |  |                                                                                                                                                     |  | 22. NAME AND ADDRESS OF FACILITY<br>CALVIN B. SCRUGGS FUNERAL HOME<br>1412 E. PRESTON ST. BALTO, MD. 21213                                                                                                                                                                                                                                                                                                                          |  |                                                                                      |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                              |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anoxic Brain injury<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                           |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| b. Hemoptysis<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                      |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| c. Old Tuberculosis<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| d.<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                 |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| 24. SEQUENTIALLY LIST CONDITIONS, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                         |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                 |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                              |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                 |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                    |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                  |  |                                                                                                                                                     |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                          |  |                                                                                      |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                           |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                      |  |                                                                                                                                                     |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                              |  |                                                                                      |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                           |  |                                                                                                                                                     |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                      |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Kelly A. Gero, Intern</i>                                                                                                                                                                                                                  |  |                                                                                                                                                     |  | 29c. LICENSE NUMBER<br>N4487                                                                                                                                                                                                                                                                                                                                                                                                        |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 28, 1995                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Kelly A. Gero 601 N. Wolfe St. Johns Hopkins Hospital, Baltimore MD 21287                                                                                                                       |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| 31. DATE FILED (Month, Day, Year)<br>DEC 01 1995                                                                                                                                                                                                                                       |  |                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
 BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |                                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                     |                                                                                       |                                                        |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>CATHERINE E. BOHAGER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |                                           | 2. DATE OF DEATH<br>MONTH NOV. DAY 29, YEAR 1995                                                                                                                                                                                                                        |                                                                                                                                                                                                     |                                                                                       |                                                        | 3. TIME OF DEATH<br>0703 A M                                                                                         |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-36-5415                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   | 6. AGE (In yrs. last birthday)<br>57 YRS. |                                                                                                                                                                                                                                                                         | 7. DATE OF BIRTH (Month, Day, Year)<br>Sept 1 1938                                                                                                                                                  |                                                                                       | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>3107 MARY AVENUE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY                                                                                                                                                                                                                   |                                                                                                                                                                                                     |                                                                                       | 9c. COUNTY OF DEATH<br>N/A                             |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |                                           | 10b. COUNTY<br>N/A                                                                                                                                                                                                                                                      |                                                                                                                                                                                                     | 10c. CITY, TOWN OR LOCATION<br>Baltimore City                                         |                                                        |                                                                                                                      | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                                        |  |                                   |  |
| 10e. STREET AND NUMBER<br>3107 Mary Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |                                           | 10f. ZIP CODE<br>21214                                                                                                                                                                                                                                                  |                                                                                                                                                                                                     |                                                                                       | 10g. CITIZEN OF WHAT COUNTRY?<br>United States         |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                           |                                                                                                                                                                                                                                                                         | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                                                                       |                                                        | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                                     |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |                                           | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Registered Nurse                                                                                                                                          |                                                                                                                                                                                                     |                                                                                       | 16b. KIND OF BUSINESS/INDUSTRY<br>Hospital             |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John P. Corcoran                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Dorothy C. Schaffer                                                                                                                                                                                                |                                                                                                                                                                                                     |                                                                                       |                                                        |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Thomas R. Corcoran                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2103 Brookhaven Court Fallston, Md. 21047                                                                                                                              |                                                                                                                                                                                                     |                                                                                       |                                                        |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |                                           | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Hilltop Service Corp. 12/1/95                                                                                                                                                        |                                                                                                                                                                                                     |                                                                                       | 20c. LOCATION — City or Town, State<br>Towson Maryland |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Milton J. Knight Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |                                           | 22. NAME AND ADDRESS OF FACILITY<br>Leonard J. Ruck, Inc.<br>5305 Harford Rd. Baltimore, Maryland 21214                                                                                                                                                                 |                                                                                                                                                                                                     |                                                                                       |                                                        |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                  |                                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                     |                                                                                       |                                                        | Approximate Interval Between Onset and Death                                                                         |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Schizophrenia                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |                                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                     |                                                                                       |                                                        | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>partial |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |                                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                     |                                                                                       |                                                        |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XX YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |                                           | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home XX Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                     |                                                                                       |                                                        |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |                                           | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                  |                                                                                                                                                                                                     | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                        | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                 |                                                                                                     |                                                                                                                                                        |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |                                           | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)                                                                                                                                                                                  |                                                                                                                                                                                                     |                                                                                       |                                                        | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                         |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                |  |                                                                                                                                                  |                                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                     |                                                                                       |                                                        |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Dennis J. Chute MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |                                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                     | 29c. LICENSE NUMBER<br>O.C.M.E                                                        |                                                        |                                                                                                                      | 29d. DATE SIGNED (Month, Day, Year)<br>NOV. 30, 1995                                                |                                                                                                                                                        |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DENNIS J. CHUTE MD 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |                                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                     |                                                                                       |                                                        |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br>DEC 01 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |                                           | 32. REGISTRAR'S SIGNATURE<br>John D. ...                                                                                                                                                                                                                                |                                                                                                                                                                                                     |                                                                                       |                                                        |                                                                                                                      |                                                                                                     |                                                                                                                                                        |  |                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95-7162-510

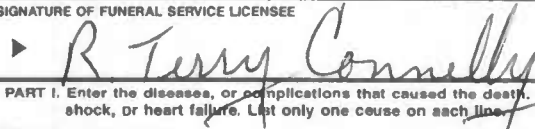
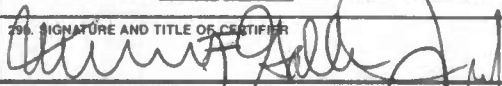
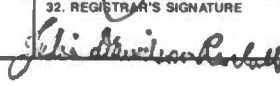
B.K.S

95 36358

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-730 12/20/95 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY BOLTON</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 27, 1995</b>                                                                                                                                                                                                                     |  |                                                                                                                           |                                                                            | 3. TIME OF DEATH<br><b>0718 A<sup>M</sup></b>                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-52-9063</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>46 YRS.</b>                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 19, 1949</b>                                                               |                                                                            | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                         |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3531 EAST FAYETTE STREET</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                   |  |                                                                                                                           |                                                                            | 9c. COUNTY OF DEATH<br><b>n/a</b>                                                                   |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br><b>n/a</b>                                                                                                                        |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3531 East Fayette Street</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  | 10f. ZIP CODE<br><b>21224</b>                                                                                                                                                                                                                                                  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                               |                                                                            |                                                                                                     |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                            |  |                                                                                                                           | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |                                                                                                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>State of Maryland</b>                                                                |                                                                            |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Clifton</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Catherine Monaghan</b>                                                                                                                                                                                                 |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Howard Webb Jr.</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3531 E. Fayette Street Baltimore Md. 21224</b>                                                                                                                             |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  |                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory Inc. 11/30/95</b>                                                                                                                                                        |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Md.</b>                                                               |                                                                            |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>COMBINED DRUG INTOXICATION</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>XX YES</b> 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home <b>XX</b> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input checked="" type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                        |  |                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11-27-95 FOUND</b>                                                                                                                                                                                                                |  | 28b. TIME OF INJURY AT WORK?<br><b>7:00 A<sup>M</sup></b>                                                                 |                                                                            | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>SUBJECT INGESTED DRUGS</b>                                                                                                                                                                                                             |  |                                                                                                                           |                                                                            |                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND AT HOME</b>                                                                                                                                                                 |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>3531 E. FAYETTE STREET BALTIMORE, MD.</b> |                                                                            |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>O.C.M.E</b>                                                                                     |                                                                            | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 27, 1995</b>                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARIO F. GOVE JR. 11 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                |  |                                                                                                                           |                                                                            |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                               |  |                                                                                                                           |                                                                            |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36359

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Virginia Coale</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 28, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>2:10 a.m.</b>                                                                                                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>089-03-9479</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                            |  | 6. AGE (In yrs. last birthday)<br><b>86 YRS.</b>                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 24, 1909</b>                                                                                             |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>ILLINOIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BROADMEAD RETIREMENT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>COCKEYSVILLE</b>                                                                                                                                          |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                                                                                |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                     |  | 10c. CITY, TOWN OR LOCATION<br><b>COCKEYSVILLE</b>                                                                                                     |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 10e. STREET AND NUMBER<br><b>13801 York Rd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                           |  | 10f. ZIP CODE<br><b>21030</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                            |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                          |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                                                                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>5+</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Education</b>                                                                                                                                                  |  |                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>The Rev. James Johnson Coale, II</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nellie Johnson</b>                                                                                                                          |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>The Rev. John Coale Fisher</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>151 E. 83rd St., New York, N.Y. 10028</b>                                                       |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>                                                                                                                                                                           |  | DATE<br><b>NOV 28</b>                                                                                                                                                                               |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, MD</b>                                                                                          |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Bryan W. Clary</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                           |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon Funeral Home of Dulaney Valley, Inc.<br/>10 W. Padonia Rd., Timonium, MD 21093</b>                                                                    |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  | Approximate Interval Between Onset and Death<br><b>24 hrs</b>                                                                                          |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER:<br>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                         |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                        |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                         |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                           |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                           |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert H. Wiedefeld M.D.</i>                                                                                                                            |  |                                                                                                                                                        |  |
| 29c. LICENSE NUMBER<br><b>D33011</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/28/95</b>                                                                                                                                              |  |                                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert H. Wiedefeld, M.D. 3346 Papermill Road, Phoenix, MD 21131</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                           |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Wiedefeld</i>                                                                                                                                               |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the examining physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.



95 36360

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Martha Thomas Crawford                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 24, 1995                                                                                                                                                                                                                                                                                                                                                                          |  | 3. TIME OF DEATH<br>1:30 AM                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br>220-30-5871                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>91 YRS.                                                                                                                                                                                                                                                                                                                                                                                        |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>July 19, 1904                                         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 9a. FACILITY NAME (If not Institution, give street and number)<br>St. Agnes Hospital                                                                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                                |  |
| 9c. COUNTY OF DEATH<br>n/a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                 |  |
| 10b. COUNTY<br>n/a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                 |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 10e. STREET AND NUMBER<br>2914 Elgin Avenue                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                 |  |
| 10f. ZIP CODE<br>21216                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                 |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)<br>6th Grade                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Domestic                                                                                                                                                                                                                                                                                                        |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Private Family                                                |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>n/a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>n/a                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Barbara Bennett                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2914 Elgin Avenue Baltimore, Maryland 21216                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| 20. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maryland National                                                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br>Laurel, Maryland                                                                                                                                                                                                                                                                                                                                                                          |  | 20d. DATE<br>NOV 29                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Barry L. Follis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>Nutter Funeral Homes, Inc.<br>2501 Gwynns Falls Parkway<br>Baltimore, Maryland 21216                                                                                                                                                                                                                                                                                                         |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)<br>φ                                                                                                                                                                                                                                                                |  | 28b. TIME OF INJURY<br>φ M                                                                                                                                                                                                                                                                                                                                                                                                       |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>φ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>φ                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>φ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Michele Kemp, MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>D31865                                                                                                                                                                                                                                                                                                                                                                                                    |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/29/95                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Rm 206 821 N Gunter street Port md 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br>DEC 01 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>L. J. Anderson                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

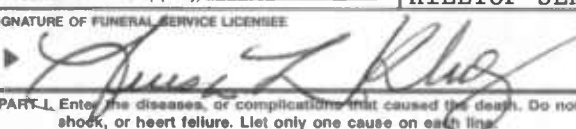


DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                            |  |                                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WARREN ANTHONY CHARCH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 23, 1995</b>                                                                                                                                  |  | 3. TIME OF DEATH<br><b>1948 P M</b>                                                                                        |  |                                                                                                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-12-7228</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAY 19, 1923</b>                                                                 |  |                                                                                                                                         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1269 RIVERSIDE AVENUE APT. #3</b>                                                                                                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                                                               |  |                                                                                                                                         |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                            |  |                                                                                                                                         |  |
| 10e. STREET AND NUMBER<br><b>1269 RIVERSIDE AVENUE - APT #3</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21230</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                             |  |                                                                                                                                         |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                    |  |                                                                                                                                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4YRS</b><br>College (1-4 or 5+) <b>4YRS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SENIOR CLERK</b>                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BETHLEHEM STEEL</b>                                                                                                                                        |  |                                                                                                                            |  |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOSEPH CHARCH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARGARET ROTHENBURG</b>                                                                                                                 |  |                                                                                                                            |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MISS. FRANCES CHARCH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1936 Harmon Avenue - Baltimore, Md 21230</b>                                                |  |                                                                                                                            |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HILLTOP SERVICE CORPORATION</b>                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><b>TOWSON</b>                                                                                                                                            |  | 20d. DATE<br><b>11/29</b>                                                                                                  |  |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME, INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>                                                                               |  |                                                                                                                            |  |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Atherosclerotic Cardiovascular disease</i></b><br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>b.<br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><b>INSPECTION</b> |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                            |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                           |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                       |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                    |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 24, 1995</b>                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                            |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                |  |                                                                                                                            |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text at the bottom of the page, possibly a signature or date.



95 36362

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                |                                                                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Gladys L. Carnaggio</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                                  | 2. DATE OF DEATH<br>MONTH <b>Nov.</b> DAY <b>26</b> YEAR <b>1995</b>                                                                                                                                |                                | 3. TIME OF DEATH<br><b>10:42a</b> M                                                                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-12-2017</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                      | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Oct. 9, 1913</b>                                                                               |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                |                                                                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Greater Baltimore Medical center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                                                                                                                                |                                | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                     |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                |                                                                                                                                             |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                            |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>                                                                                                                                                         |                                | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><b>1000 Franklin Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                                  | 10f. ZIP CODE<br><b>21221</b>                                                                                                                                                                       |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                              |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b><br>College (1-4 or 5+) <b>Housewife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                                                                                                                                                                          |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>                                                                                                                                                   |                                |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Israel Mickely</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margarette Richter</b>                                                                                                                      |                                |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Barbara Ann Jefferson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>874 Seneca Park Rd. Balt. MD. 21220</b>                                                         |                                |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenmount Crematory</b> DATE <b>11/28/95</b>                                                                                                                                                                        |                                                  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD.</b>                                                                                                                                        |                                |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bruzdinski Funeral Home P.A.</b><br><b>1407 Old Eastern Ave. Balt., MD. 21221</b>                                                                                                                                                                                   |                                                  |                                                                                                                                                                                                     |                                |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MI</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>CHRONIC RENAL FAILURE</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>PERIPHERAL VASCULAR DISEASE</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><b>7 yrs</b><br><b>5 years</b> |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                |                                                                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                     |                                |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                                  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |                                                  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |                                |                                                                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                |                                                                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                                  | 29c. LICENSE NUMBER<br><b>072545</b>                                                                                                                                                                |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/28/95</b>                                                                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Harvey S. Mishner MD 2300 York Rd #218 Timonium Md 21093</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

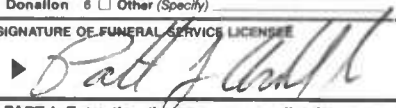
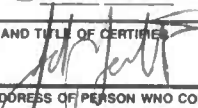

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2005-2006

95 36363

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lynn Marie Coleman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 29, 1995</b>                                                                                                                                  |  | 3. TIME OF DEATH<br><b>1350</b>                                                                 |                                                                                                                                                     |
| 4. SOCIAL SECURITY NUMBER<br><b>219-54-3810</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br><b>44</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 2, 1951</b>                                      |                                                                                                                                                     |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                     |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>                                                                                                                                         |  | 8c. COUNTY OF DEATH<br><b>Anne Arundel</b>                                                      |                                                                                                                                                     |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                     |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br><b>Queen Anne</b>                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>Chester</b>                                                                                                                                                   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                                     |
| 10e. STREET AND NUMBER<br><b>308 Dominion Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  | 10f. ZIP CODE<br><b>21619</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                                                                     |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |                                                                                                                                                     |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>                                                                                                                                                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Md. Transit Auth. Police</b>                                                                                                                               |  |                                                                                                 |                                                                                                                                                     |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Lee Smith</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Doris L. Johnson</b>                                                                                                                    |  |                                                                                                 |                                                                                                                                                     |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Richard Coleman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>308 Dominion Road, Chester, MD 21619</b>                                                    |  |                                                                                                 |                                                                                                                                                     |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                           |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hillcrest Cemetery</b>                                                                                                                                                                        |  | DATE<br><b>12/1</b>                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br><b>Annapolis, MD</b>                                     |                                                                                                                                                     |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</b>                                                                                  |  |                                                                                                 |                                                                                                                                                     |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>s. metastatic Carcinoma of the tongue</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death                                                                                                        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Tobacco smoking</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                               |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                     |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                                                                     |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                     |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |                                                                                                                                                     |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                     |
| 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                     |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br><b>D32654</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/29/95</b>                                          |                                                                                                                                                     |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John Serlemitsos 180 Admiral Cochrane Dr., Annapolis, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                     |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                    |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                     |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36364

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOSEPH MICHAEL CROGHAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 27, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>10:25 P.M.</b>                                                                                                                                          |                                                                                                                                         |
| 4. SOCIAL SECURITY NUMBER<br><b>214-16-6846</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct. 1, 1921</b>                                                                                                                     |                                                                                                                                         |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Manor Care Ruxton</b>                                                                                                      |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                                                                                                           |                                                                                                                                         |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>Md.</b>                                                                                                                                                                        |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                |                                                                                                                                         |
| 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>205 E. Joppa Rd. #2209</b>                                                                                                                        |                                                                                                                                         |
| 10f. ZIP CODE<br><b>21286</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |                                                                                                                                         |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW-II</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                                                     |                                                                                                                                         |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sports Announcer</b>                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Radio &amp; Television</b>                                                                                                                |                                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Croghan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ann Collins</b>                                                                                                                         |  |                                                                                                                                                                                |                                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Melva Croghan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>205 E. Joppa Rd. #2209 Towson, Md. 21286</b>                                                |  |                                                                                                                                                                                |                                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemetery 11/30/95</b>                                                                       |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>                                                                                                                   |                                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>                                                                                   |  |                                                                                                                                                                                |                                                                                                                                         |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Aspiration Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Metastatic Sarcoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                | Approximate Interval Between Onset and Death<br><b>2 wks</b><br><b>1 year</b>                                                           |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                                                         |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                               |                                                                                                                                         |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                                                                                                |                                                                                                                                         |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M Boyle MD - Faculty GBMC</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D46141</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/28/95</b>                                                                                                                         |                                                                                                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Michael P. Boyle, M.D. GBMC 6565 N. Charles St. Baltimore MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                   |  |                                                                                                                                                                                |                                                                                                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36365

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Thomas Byrne Connor, Sr.</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>Nov.</b> DAY <b>30</b> YEAR <b>1995</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>4:00 a.m.</b>                                                                                                                   |                                                              |
| 4. SOCIAL SECURITY NUMBER<br><b>217-16-1366</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 8. AGE (In yrs. last birthday)<br><b>73</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 21, 1921</b>                                                                                            |                                                              |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>111 Hamlet Hill Road Apt. 1106</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                      |                                                              |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                        |                                                              |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 10e. STREET AND NUMBER<br><b>111 Hamlet Hill Road Apt. 1106</b>                                                                                                                                     |  |                                                                                                                                                        |                                                              |
| 10f. ZIP CODE<br><b>21210</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                      |  |                                                                                                                                                        |                                                              |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMY FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>                                                                                                                                         |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                                |                                                              |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+ years</b>                                                                                                                                                                                                                                                                                                               |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Physician</b>                                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Academic</b>                                                                                                                                                   |  |                                                                                                                                                        |                                                              |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John S. Connor</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anne Loretta McCabe</b>                                                                                                                     |  |                                                                                                                                                        |                                                              |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Eleanor R. Connor</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>111 Hamlet Hill Road. Apt. 1106 Balto., MD 21210</b>                                            |  |                                                                                                                                                        |                                                              |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Gdn's. 12/04</b>                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br><b>Timonium, Maryland</b>                                                                                                                                    |  | 20d. DATE<br><b>12/04</b>                                                                                                                              |                                                              |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home Inc. 6500 York Rd Baltimore, MD 21212</b>                                                                                            |  |                                                                                                                                                        |                                                              |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |                                                              |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                               |  | a. <b>SEPTIC SHOCK</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                                                                        | Approximate Interval Between Onset and Death<br><b>1 day</b> |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                      |  | b. <b>PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                     |  |                                                                                                                                                        | <b>5 days</b>                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | c. <b>PROSTATIC ADENOCARCINOMA With Bony Metastases</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                        | <b>5 yrs</b>                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | d.                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |                                                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hepatitis C - probable chronic liver disease</b>                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |                                                              |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                           |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                              |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                        |                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28d. DESCRIBE HOW INJURY OCCURED                                                                                                                                                                                                                                                                           |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                           |                                                              |
| 29. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |                                                              |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John F. Rogers</i>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D16534</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/30/95</b>                                                                                                 |                                                              |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John Rogers, M.D. 5601 Loch Raven Blve. Suite 502 Balto., MD 21239</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |                                                              |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                     |  |                                                                                                                                                        |                                                              |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>CARY RUSSELL DAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>29</b> YEAR <b>1995</b>                                                                                                                             |  | 3. TIME OF DEATH<br><b>1416 P M</b>                                                                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>262 67 7031</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                |  | 6. AGE (In yrs. last birthday)<br><b>33</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MAR 13 1962</b>                                                                                       |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                           |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Union Hospital</b>                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Elkton</b>                                                                                               |  |
| 9c. COUNTY OF DEATH<br><b>Cecil</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                           |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                   |  |                                                                                                                                                    |  |
| 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>                                                                                                                                                     |  |                                                                                                                                                    |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  | 10e. STREET AND NUMBER<br><b>2 Fore Ct.</b>                                                                                                                                                     |  |                                                                                                                                                    |  |
| 10f. ZIP CODE<br><b>21221</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                           |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                     |  |                                                                                                                                                    |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>U.S. NAVY</b>                                                                                                                                       |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Disabled American Veteran</b>                                                                                                                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Military</b>                                                                                                                                               |  |                                                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Kermit Russell Day</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Micheline Marie Sandre</b>                                                                                                              |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Micheline M. Hall</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2 Fore Ct., Balto., MD 21221</b>                                                            |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial Gardens</b>                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br><b>Timonium, MD</b>                                                                                                                                      |  | 20d. DATE OF DISPOSITION<br><b>12/2/95</b>                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Bryan W. Clary</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                           |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon Funeral Home</b><br><b>10 W. Padonia Rd., Timonium, MD 21093</b>                                                                                  |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Drug Overdose</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><b>6 hours</b> |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  | 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Schizophrenia</b> |  |
| 24. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  | 24c. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>N/A</b>                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br><b>N/A</b>                                                                                                                                                               |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>N/A</b>                                                                                                                                                                                                      |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>N/A</b>                                                                                                      |  | 28g. DATE SIGNED (Month, Day, Year)<br><b>November 29, 1995</b>                                                                                    |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                      |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>H. Farkas, MD</b>                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>D15314</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 29, 1995</b>                                                                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>H. Farkas MD Union Hospital, Elkton, MD 21921</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 32. REGISTERED MEDICAL EXAMINER<br><b>John W. Randall</b>                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36367

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Thomas P. DANAHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                          |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 29, 1995                                                                                                                                             |  | 3. TIME OF DEATH<br>2:19 PM                                                                         |                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br>213-18-3997                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                           |  | 6. AGE (In yrs. last birthday)<br>83 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>FEB 5, 1912                                                  |                                                                                                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br>FRANKLIN SQUARE HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                          |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rossville                                                                                                                                                    |  | 9c. COUNTY OF DEATH<br>Baltimore county                                                             |                                                                                                                                             |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 10a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br>Baltimore                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br>Carney                                                                                                                                                               |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                             |
| 10e. STREET AND NUMBER<br>8800 Walther Blvd #2611                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                          |  | 10f. ZIP CODE<br>21234                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                |                                                                                                                                             |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |                                                                                                                                             |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (14 or 5+) —                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>AUDITOR                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br>STATE of Md.                                                                                                                                                      |  |                                                                                                     |                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br>Joseph Danaher                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Flynn                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br>Anne P. Danaher                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                          |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8800 Walther Blvd. #2611 Balto. Md. 21234                                                          |  |                                                                                                     |                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                               |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>New CATHEDRAL                                                         |  | 20c. LOCATION — City or Town, State<br>12/2/95 BALTO. Md.                                                                                                                                           |  |                                                                                                     |                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Robert W. Graves Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                          |  | 22. NAME AND ADDRESS OF FACILITY<br>EVANS CHAPEL OF MEMORIES<br>8800 HARFORD Rd Balto. Md. 21234                                                                                                    |  |                                                                                                     |                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. Atherosclerotic Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death<br>1 day                                                                                       |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Old Cerebrovascular Accident<br>Old Myocardial Infarction<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                   |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                        |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                              |  |                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Veronica Deza, MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                          |  | 29c. LICENSE NUMBER<br>P09197                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 29, 1995                                            |                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Veronica Deza, M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br>DEC 01 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br>John A. ...                                                                                                                                                            |  |                                                                                                     |                                                                                                                                             |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36368

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOSEPH MICHAEL DUFFY</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 29, 1995</b>                                                                                                                                  |  | 3. TIME OF DEATH<br><b>1137A</b>                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-12-9358</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 20, 1925</b>                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Carroll County General Hospital</b>                                                                                                                                                                                       |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>                                                                                                                                       |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>                                                           |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Reisterstown</b>                                                                                                                                              |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>413 E. Cherry Hill Road</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21136</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machinist</b>                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Manufacturing</b>                                          |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Michael J. Duffy</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Margaret Dougherty</b>                                                                                                             |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Edward J. Duffy</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>413 E. Cherry Hill Rd. Reisterstown, Md. 21136</b>                                          |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet. Cem. 12-1-95 Owings Mills, Md.</b>                                                                                                                                                  |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  | 20d. DATE                                                                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>E. Brian Powell</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>11824 Reisterstown Road<br/>Eline Funeral Home Reisterstown, Md. 21136</b>                                                                               |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| b. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| c. <b>SEPSIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| d. <b>MULTIINFARCT DEMENTIA</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                    |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dan H. Schneisfer MD</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D28221</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 29, 1995</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DAN H. SCHNEISFER, MD 200 MEMORIAL AVENUE WESTMINSTER, MARYLAND</b>                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



OHMH-18 Rev 1/89

10





ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-730 12/11/95 t.t

95 36370

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ERIC TODD DUGAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 29, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>11:05 A.M.</b>                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-86-6468</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>31</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 29, 1964</b>                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>810 GEORGES ST.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Essex</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                     |  |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>                                                 |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 10e. STREET AND NUMBER<br><b>810 George Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21221</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                 |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2yrs</b> College (1-4 or 5+) <b>2yrs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Chef</b>                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>n/a</b>                                                |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Tubens</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Shirley Gietka</b>                                                                                                                      |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Shirley Grove</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>802 Delray Court Forest Hill Md. 21050</b>                                                  |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery 12/4/95</b>                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Md.</b>                                                                                                                                     |  |                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>R. Terry Connelly</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>                                                                                 |  |                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE NARCOTIC INTOXICATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input checked="" type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                          |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>FOUND 11-29-95</b>                                                                                                                                                                                                                                |  | 28b. TIME OF INJURY<br><b>11:00 A.M.</b>                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>UNKNOWN</b>                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND AT HOME</b>                                                                                  |  |                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>810 GEORGES AVENUE ESSEX, MARYLAND</b>                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dennis J. Chute MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>OCME</b>                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 30, 1995</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DENNIS J. CHUTE MD. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILLED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36371

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                                |                                                                                                                                                 |                                                                                                                                                                                                 |                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES H. ENGLISH, SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                                | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 27, 1995</b>                                                                                  |                                                                                                                                                                                                 | 3. TIME OF DEATH<br><b>2:00 A M</b>                                                                                                     |
| 4. SOCIAL SECURITY NUMBER<br><b>214-20-7919</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.                                                                                                                                                                                                                                               | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Apr. 11, 1925</b>                                                                                     |                                                                                                                                                                                                 | 8. BIRTHPLACE (State or Foreign Country)<br><b>S. Carolina</b>                                                                          |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1521 Shadyside Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                         |                                                                                                                                                                                                 | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                       |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                                                                                                                |                                                                                                                                                 |                                                                                                                                                                                                 |                                                                                                                                         |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 10b. COUNTY<br><b>N/A</b>                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                |                                                                                                                                                 | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                 |                                                                                                                                         |
| 10e. STREET AND NUMBER<br><b>1521 Shadyside Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | 10f. ZIP CODE<br><b>21218</b>                                                                                                                                                                                                                                                                  |                                                                                                                                                 | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                  |                                                                                                                                         |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |                                                                                                                                                 | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                                                                                                                         |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>8th</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>                                                                                                                                                                |                                                                                                                                                 | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Bethlehem Steel</b>                                                                                                                                        |                                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Alex English</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Carrie Davis</b>                                                                        |                                                                                                                                                                                                 |                                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Julia English</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1521 Shadyside Road/Baltimore, MD 21218</b> |                                                                                                                                                                                                 |                                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>NEW HOME INDEPENDENT AME CH. CEM. 12-1 WOODARD, S.C.</b>                                                                                                                                                 |                                                                                                                                                 | 20c. LOCATION — City or Town, State<br><b>SHIP</b>                                                                                                                                              |                                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Glenn Mahoney Davis</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                                                                                                                                                                | 22. NAME AND ADDRESS OF FACILITY<br><b>March Funeral Home East<br/>1101 E. North Avenue/Baltimore, MD 21202</b>                                 |                                                                                                                                                                                                 |                                                                                                                                         |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. END STAGE ALZHEIMER'S</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><br><b>d.</b> |                                                                            |                                                                                                                                                                                                                                                                                                |                                                                                                                                                 |                                                                                                                                                                                                 | Approximate Interval Between Onset and Death                                                                                            |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                                                                                                                |                                                                                                                                                 |                                                                                                                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                                                                                                                                |                                                                                                                                                 |                                                                                                                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                 |                                                                                                                                                                                                 |                                                                                                                                         |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                 | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                  |                                                                            | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Shelly Thomas</i>                                                                                                                                                                                                                                  |                                                                                                                                                 | 29c. LICENSE NUMBER<br><b>D33215</b>                                                                                                                                                            | 29d. DATE SIGNED (Month, Day, Year)<br><b>12/1/95</b>                                                                                   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20, Type, City)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                |                                                                                                                                                 |                                                                                                                                                                                                 |                                                                                                                                         |
| <b>SHELLY THOMAS, 100 WEST ROAD, TOWSON, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                                                                                                                |                                                                                                                                                 |                                                                                                                                                                                                 |                                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>                                                                                                                                                                                                                                                |                                                                                                                                                 |                                                                                                                                                                                                 |                                                                                                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36372

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>AGNES MARY ESSLINGER</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>30</b> YEAR <b>1995</b>                                                                                                                                                                                                                                                                                             |  | 3. TIME OF DEATH<br><b>4:10 A M</b>                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-22-9443</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.                                                                                                                                                                                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JULY 21, 1927</b>                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  | 9. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                                |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                     |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>LANSDOWNE</b>                                             |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  | 10e. STREET AND NUMBER<br><b>2111 GAYLAND DRIVE</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                             |  |
| 10f. ZIP CODE<br><b>21227</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                             |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                     |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                 |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH GRADE</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>                                                                                                                                                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOMEMAKING</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EUGENE L. BRENNAN</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARIE ZINKAND</b>                                                                                                                                                                                                                                                                                       |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>WILLIAM G. ESSLINGER</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2111 GAYLAND DRIVE - LANSDOWNE, MD. 21227</b>                                                                                                                                                                                                               |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MEADOWRIDGE MEMORIAL PARK 12/4</b>                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br><b>ELKRIDGE</b>                                                                                                                                                                                                                                                                                                          |  | 20d. DATE<br><b>12/4</b>                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jackie H. Shannon</i>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                     |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME, INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>                                                                                                                                                                                                                                               |  |                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart failure</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>Acute Myocardial Infarction</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus (10 years)</b><br><b>Bilateral embolic stroke</b>                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                              |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                    |  | 28g. DATE OF INJURY                                                                         |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mutombo Kankonde, MD</i>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br><b>D46704</b>                                                                                                                                                                                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 30, 1995</b>                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MUTOMBO KANKONDE, ST AGNES HOSPITAL BLT MD</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b> <i>John D. ...</i>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or date, located at the bottom right of the page.

Glenn Elder

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Glenn Wayne Elder</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 24 1995</b>                                                                                                                                           |  | 3. TIME OF DEATH<br><b>12:55 P M</b>                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>238-30-7487</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 27, 1926</b>                                         |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Salisbury Nursing &amp; rehab Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury, Md.</b>                                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>                                                              |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Somerset</b>                                                                                                                                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br><b>Marion Station</b>                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4048 Shell Town Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21838</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                      |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Korean War</b>                                                                                                                                      |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Crane Operator</b>                                                                                                                                                                        |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Steel Mill</b>                                                                                                                                                 |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Glenn N. Elder</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ada Overcash</b>                                                                                                                            |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Josephine Elder</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4048 Shell Town Rd. Marion Station, MD. 21838</b>                                               |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gardens Of Faith Cem. 11/30/1995 Baltimore, MD.</b>                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State                                                                                                                                                                 |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bruzdinski Funeral Home P.A.<br/>1407 Old Eastern Ave. Balt. MD. 21221</b>                                                                                   |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Metastatic Melanoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Diabetes</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                     |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D-29349</b>                                                                                                                                                               |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/24/95</b>                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WILLIAM ROBINS, M.D., 1104 HEALTHWAY DRIVE, SALISBURY, MD. 21801</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                       |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

the United States Bill 10-1



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Dolores Freund</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 29 1995</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 3. TIME OF DEATH<br><b>7:25 P M</b>                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-44-6431</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>93</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.                                                                                                                                                                                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct. 22 1902</b>                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1100 Long Brook Rd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Lutherville</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                     |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 10c. CITY, TOWN OR LOCATION<br><b>Lutherville</b>                                           |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 10e. STREET AND NUMBER<br><b>1100 Long Brook Rd.</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                             |  |
| 10f. ZIP CODE<br><b>21093</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                             |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John T. Mooney</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Roberta K. Arringdale</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Frederick G. Freund</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1100 Long Brook Rd., Lutherville, MD 21093</b>                                                                                                                                                                                                                                                                           |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of)<br><b>NEIRO CREMATORY</b><br><b>Woodlawn Cemetery</b>                                                                                                                                                                                          |  | 20c. LOCATION<br><b>CATONSVILLE, MD</b><br><b>Woodlawn, MD</b>                                                                                                                                                                                                                                                                                                                                                               |  | 20d. DATE<br><b>12/1/95</b>                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lowell M. Lemmon</i><br><b>Lowell M. Lemmon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon Funeral Home</b><br><b>10 W. Padonia Rd., Timonium, MD 21093</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute myocardial infarction</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Coronary artery disease</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><b>1 hr</b><br><b>25 yrs.</b> |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |  |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Renal Failure</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                             |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                                             |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Paul J. Edgar, MD</i><br><b>Paul J. Edgar, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>001939</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>12/1/95</b>                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Paul J. Edgar, MD 515 Fairmont Ave., Towson, MD 21286</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |  |
| 31. DATE FILED<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                             |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JACK F. GREENHOLTZ</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 30 1995</b>                                                                                                                                            |  | 3. TIME OF DEATH<br><b>1:05 P M</b>                                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-03-6049</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                                                 |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug 23, 1917</b>                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Johns Hopkins Bayview M.C.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                      |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Dundalk</b>                                                                                                                                                       |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><b>1822 Robinwood Rd</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21222</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                            |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>                                                                                                                                                               |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b><br>College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Plumbing</b>                                                                                                                                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Federal Government</b>                                                                                                                                         |  |                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Greenholtz</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Eva Barksdale</b>                                                                                                                           |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ethel Greenholtz</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1822 Robinwood Rd Baltimore, Md 21222</b>                                                       |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet 12-4</b>                                                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, Md</b>                                                                                                                                      |  | 20d. DATE                                                                                                                                              |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Anthony Colt Connelly</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home of Dundalk<br/>7110 Sollers Point Rd 21222</b>                                                                                         |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anoxic Brain Damage</b><br><b>b. Heart Failure</b><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b><br>c. <b></b><br>d. <b></b> |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  | Approximate Interval Between Onset and Death<br><b>24 hours</b><br><b>6 months</b>                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                               |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Sudden 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                        |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                           |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Patrick A. Ijewere M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>94007</b>                                                                                                                                                                 |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-30-95</b>                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Patrick A. Ijewere 4940 Eastern Avenue Balt., Md 21224</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>John B. Parker</b>                                                                                                                                                  |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36376

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KESSIE OLA GARNER</b>                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 30 95</b>                                                                                                                                              |  | 3. TIME OF DEATH<br><b>0850 A M</b>                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-22-2924</b>                                                                                                                                                                                                                             |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAY 12, 1918</b>                                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>NORTH CAROLINA</b>                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                         |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                       |  | 10b. COUNTY<br><b>BALTIMORE CITY</b>                                                            |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>4812 STAFFORD STREET</b>                                           |  |
| 10f. ZIP CODE<br><b>21229</b>                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                      |  |                                                                                                 |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                      |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>H/S GRAD</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>STOCK HANDLER</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>MONTGOMERY WARDS</b>                                                                                                                                           |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM BALDWIN</b>                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>VIOLA MARSH</b>                                                                                                                             |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. GERTRUDE LUCAS</b>                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4810 STAFFORD STREET - BALTIMORE, MD 21229</b>                                                  |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BALTO NATIONAL CEMETERY</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 20c. LOCATION — City or Town, State<br><b>12/4 BALTIMORE</b>                                                                                                                                        |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kevin P. Smith</b>                              |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME, INC.</b>                                                                                                                                                                                                       |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Failure</b><br><b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br><b>Metastatic Breast Carcinoma</b> |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                         |  | 25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                             |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                           |  | 29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 29b. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                 |  |
| 29c. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                  |  | 29d. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 29e. LICENSE NUMBER<br><b>D19419</b>                                                                                                                                                                                                                                        |  | 29f. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 30, 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DIANA H. GRIFFIN 900 CATON AVE. BALTIMORE, MD 21229</b>                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                     |                                                                                                                                                                                                 |                                                             |                                                                                                 |                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Helen Avery Hetherington</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |                                                     | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 26, 1995</b>                                                                                                                                  |                                                             | 3. TIME OF DEATH<br><b>7:27 P.</b>                                                              |                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-40-1036</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br><b>92</b> 93 YRS. |                                                                                                                                                                                                 | 7. DATE OF BIRTH (Month, Day, Year)<br><b>AUG. 15, 1902</b> |                                                                                                 | 8. BIRTHPLACE (State or Foreign Country)<br><b>Rhode Island</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Presbyterian Home of Maryland</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |                                                     | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                                                                                                                            |                                                             | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>                                                  |                                                                 |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |                                                     |                                                                                                                                                                                                 |                                                             |                                                                                                 |                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Baltimore County</b>                                                                                                                                                                                                                                                         |                                                     | 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>                                                                                                                                                    |                                                             | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                 |  |
| 10e. STREET AND NUMBER<br><b>400 Georgia Court</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                     | 10f. ZIP CODE<br><b>21204</b>                                                                                                                                                                   |                                                             | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |                                                                 |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |                                                     | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                                             | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |                                                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>                                                                                                                                                                                                                                                                                                                     |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Asst. Professor of Zoology</b>                                                                                                                                             |                                                     | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private College</b>                                                                                                                                        |                                                             |                                                                                                 |                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Avery</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                     | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian Brown</b>                                                                                                                       |                                                             |                                                                                                 |                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Anne H. McCullough</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                     | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. box 408 1442 Horseshoe Trail, Chester Springs, PA 19425</b>                            |                                                             |                                                                                                 |                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial</b>                                                                                                                                                                              |                                                     | 20c. LOCATION — City or Town, State<br><b>12/02 Lutherville, Maryland</b>                                                                                                                       |                                                             |                                                                                                 |                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                     | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home, Inc.<br/>6500 York Rd. Baltimore, Maryland 21212</b>                                                                            |                                                             |                                                                                                 |                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |                                                     |                                                                                                                                                                                                 |                                                             |                                                                                                 |                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  | a. <b>Conjunctive Heart Failure</b>                                                                                                                                                                                                                                                            |                                                     |                                                                                                                                                                                                 |                                                             |                                                                                                 | Approximate interval Between Onset and Death<br><b>weeks</b>    |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  | b. <b>Arteriosclerotic Cardiovascular Disease</b>                                                                                                                                                                                                                                              |                                                     |                                                                                                                                                                                                 |                                                             |                                                                                                 | <b>years</b>                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | c. _____                                                                                                                                                                                                                                                                                       |                                                     |                                                                                                                                                                                                 |                                                             |                                                                                                 |                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | d. _____                                                                                                                                                                                                                                                                                       |                                                     |                                                                                                                                                                                                 |                                                             |                                                                                                 |                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Insufficiency</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |                                                     |                                                                                                                                                                                                 |                                                             |                                                                                                 |                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                        |                                                     |                                                                                                                                                                                                 |                                                             |                                                                                                 |                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |                                                     |                                                                                                                                                                                                 |                                                             |                                                                                                 |                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                     |                                                                                                                                                                                                 |                                                             |                                                                                                 |                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |                                                     | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |                                                             | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                              |                                                     |                                                                                                                                                                                                 |                                                             | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |                                                     |                                                                                                                                                                                                 |                                                             |                                                                                                 |                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>S.J. Venable, MD.</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |                                                     | 29c. LICENSE NUMBER<br><b>D-11026</b>                                                                                                                                                           |                                                             | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 27, 1995</b>                                     |                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S.J. Venable, MD. 610 Wilton Road, Towson, Maryland 21286</b>                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                                     |                                                                                                                                                                                                 |                                                             |                                                                                                 |                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                                     | 32. REGISTRAR'S SIGNATURE<br>                                                                                |                                                             |                                                                                                 |                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36378

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary Jane HYLTON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                          |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>29</b> YEAR <b>1995</b>                                                                                                                                                                                                                                                                                                                                                            |  | 3. TIME OF DEATH<br><b>8:15 P M</b>                                                                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-32-9164</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                           |  | 6. AGE (In yrs. last birthday)<br><b>58</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan 26, 1937</b>                                                                                                                             |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                          |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>                                                                                                                                                                                                                                                                                                                                   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rosedale</b>                                                                                                                                 |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                          |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                        |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Dundalk</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                          |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                 |  | 10e. STREET AND NUMBER<br><b>3110 Cornwall Rd</b>                                                                                                                                      |  |
| 10f. ZIP CODE<br><b>21222</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                          |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                          |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                 |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Cleaning Technician</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                          |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cleaning Technician</b>                                                                                                                                                                                                                                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Fire and Water Restoration</b>                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Hess</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Evelyn Miller</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Franklin D. Hylton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                          |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3110 Cornwall Rd Baltimore, Md 21222</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cem. Sacred Heart of Jesus 12-2</b>                                                                                                                                                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md</b>                                                                                                                            |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Anthony Colt Connelly</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                          |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home of Dundalk<br/>7110 Sollers Point Rd 21222</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Lung cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><b>6 months</b> |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                          |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                          |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M. Hylton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                          |  | 29c. LICENSE NUMBER<br><b>D4547+</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-29-95</b>                                                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Mohammad Rahnama 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36379

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GENEVA R. HARRELL</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>Nov</b> DAY <b>28</b> YEAR <b>1995</b>                                                                                                                             |  | 3. TIME OF DEATH<br><b>11:30A M</b>                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>237-44-4994</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAY 18, 1923</b>                                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MONTGOMERY CO, NC</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 9. COUNTY OF DEATH<br><b>n/a</b>                                                                                                                                                                |  |                                                                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>HAVEN NURSING HOME</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>n/a</b>                                                               |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                               |  | 10b. COUNTY<br><b>n/a</b>                                                                                                                                                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1118 BARCLAY STREET</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21202</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                           |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10 th</b><br>College (1-4 or 5+) <b>-</b>                                                                                                                                                                                                                                                                                 |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>NURSE</b>                                                                                                                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>PRIVATE DUTY</b>                                                                                                                                           |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GEORGE RIDENHOUR</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ALBERTA PEMBERTON</b>                                                                                                                   |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>VERNAL A. HARRELL</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3318 HAYWARD AVENUE, BALTIMORE, MD 21215</b>                                                |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                       |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BALTIMORE NATIONAL CEM. 12-3</b>                                                                                                                                                                         |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>                                                                                                                                     |  | 20d. DATE<br><b>11/29/95</b>                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MARCH FUNERAL HOME EAST<br/>1101 E. NORTH AVENUE/BALTIMORE, MD 21202</b>                                                                                 |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute myocardial infarction suspected</b> Approximate Interval Between Onset and Death <b>1/2 HR</b>                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Due to (or as a consequence of): <b>Atherosclerotic heart disease</b> <b>54rs</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Due to (or as a consequence of): <b>Constrictive heart failure</b> <b>54rs</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Due to (or as a consequence of): <b>Cardiac arrhythmias</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 28g. DATE SIGNED (Month, Day, Year)<br><b>11/29/95</b>                                                                                                                                          |  |                                                                                                 |  |
| 29. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>030494</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/29/95</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>K. DESAIA 4660 Wilkens Ave Suite 308 Baltimore MD 21229</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM BARRY HOLBROOK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 28 1995</b>                                                                                                                                        |  | 3. TIME OF DEATH<br><b>3:45 A M</b>                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-90-9130</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>31</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>FEB. 12, 1964</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MARYLAND SHOCK TRAUMA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                               |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>Harford</b>                                                                                                                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br><b>Bel Air</b>                                                                                                                                                   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>704 Country Village Dr. Apt. 1C</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21014</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Salesman Sales Manager</b>                                                                                                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Auto Industry</b>                                                                                                                                          |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Albert Crawford Holbrook, Sr. Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Helen Elizabeth Powers</b>                                                                                                              |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patricia Ida Holbrook</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>704 Country Village Dr. Apt. 1C BelAir, MD 21014</b>                                        |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of facility, crematory or other place)<br><b>Metro Crematory, Inc. 11/30/95</b>                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>                                                                                                                                     |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George E. MacNabb</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</b>                                                                                                                                                                       |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Contusion of Head of Head</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>Found 11/28/95</b>                                                                                                                                                                                                                                |  | 28b. TIME OF INJURY<br><b>130 P.M.</b>                                                                                                                                                          |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject shot self</b>                                                                                                                                                                                                                                  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>2505 Whitt Road Harford County Maryland</b>                                                                  |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                             |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Theodore M. King</b>                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 29c. LICENSE NUMBER<br><b>O.C.M.E</b>                                                                                                                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 28, 1995</b>                                                                                                                                      |  |                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><b>John H. [Signature]</b>                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Gary Lee Hildebrand</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br><b>NOV. 30, 1995</b> YEAR                                                                                                                                                   |  | 3. TIME OF DEATH<br><b>3:30 A</b> M                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-72-5990</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>37</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br><b>April 26, 1958</b> (Month, Day, Year)                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Essex</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                         |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>15 Homberg Avenue</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Dundalk</b>                                                                                                                                                   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>57 Shipping Place Apt. 320</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21222</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATHS                                                                                                                                                   |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br><b>12</b><br>Elementary/Secondary (0-12) College (1-4 or 5+)                                                                                                                                                                                                                                                                                           |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Unemployed</b>                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Unemployed</b>                                                                                                                                             |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Dabney Hildebrand</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Charlotte Monn</b>                                                                                                                      |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charlotte Mullen</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15 Homberg Ave. Essex, Maryland 21221</b>                                                   |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery 12/2/1995</b>                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD.</b>                                                                                                                                    |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Richard Bruzdinski</i>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bruzdinski Funeral Home P.A.<br/>1407 Old Eastern Ave. Balt., MD. 21221</b>                                                                              |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Chronic myeloid leukemia</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Charles Schiffer</i>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D17988</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/30/95</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHARLES SCHIFFER MD UMCC 22 S. GREENE ST BALTIMORE MD</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>11/30/95</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36382

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Dorothy A. HUGHES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>26</b> , YEAR <b>1995</b>                                                                                                                          |  | 3. TIME OF DEATH<br><b>2:20 pm.</b>                                                  |                                                                               |
| 4. SOCIAL SECURITY NUMBER<br><b>212-80-0458</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 8. AGE (In yrs. last birthday)<br><b>82</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan. 3, 1913</b>                        |                                                                               |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>Baltimore county</b>                                       |                                                                               |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Waverly</b>                                        |                                                                               |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 10e. STREET AND NUMBER<br><b>2309 Maryland Ave.</b>                                                                                                                                                 |  |                                                                                      |                                                                               |
| 10f. ZIP CODE<br><b>21218</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                      |  |                                                                                      |                                                                               |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>           |                                                                               |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>3</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>                                    |                                                                               |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George E. Knauff</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Agnes A. Hobbs</b>                                                                                                                          |  |                                                                                      |                                                                               |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Patricia A. Johns</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1311 Blue Mount Rd. Monkton, Md. 21111</b>                                                      |  |                                                                                      |                                                                               |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Louis Cemetery 11/30/95</b>                                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br><b>Clarksville, Md.</b>                                                                                                                                      |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                        |                                                                               |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                               |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. Aspiration pneumonia with severe mucous plugging of trachea and bronchi.</b><br><b>b. Diffuse softening of brain probable ischemic changes.</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      | Approximate Interval Between Onset and Death<br><b>14 days</b>                |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Fracture hip and shoulder antecedent to admission to hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      | 24a. WAS AN AUTOPSY PERFORMED?<br><b>XX YES 2 <input type="checkbox"/> NO</b> |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>XX YES 2 <input type="checkbox"/> NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                               |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                               |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>XX YES 2 <input type="checkbox"/> NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                               |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                               |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                      |                                                                               |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                               |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                               |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>H35593</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/28/95</b>                               |                                                                               |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John Loh, M.D. 1124 Mace Avenue Baltimore, MD 21221</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                               |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                       |  |                                                                                      |                                                                               |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36383

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                     |  |                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mabel Virginia Justis</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>27</b> YEAR <b>1995</b>                                                                                                                            |  | 3. TIME OF DEATH<br><b>4:50 p.m.</b>                                                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-44-2914</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JANUARY 7, 1908</b>                                                                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Keswick Home</b>                                                                                                               |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                  |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                       |  |                                                                                                                                          |  |
| 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                     |  |                                                                                                                                          |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10e. STREET AND NUMBER<br><b>700 W. 40th Street</b>                                                                                                                                                 |  |                                                                                                                                          |  |
| 10f. ZIP CODE<br><b>21211</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                               |  |                                                                                                                                          |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Stenographer</b>                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Legal</b>                                                                                           |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Isaiah Justis</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret McCallister</b>                                                                                                                    |  |                                                                                                                                          |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Keswick Home Medical Records</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>700 W. 40th Street Baltimore, Maryland 21211</b>                                                |  |                                                                                                                                          |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                                   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Steven T. Little</i>                                                                     |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home, Inc.<br/>6500 York Road Baltimore, Maryland 21212</b>                                                                                                                                                                                                                                                                                                            |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Multiple sclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>40 years</b> |  |                                                                                                                                                                                                     |  |                                                                                                                                          |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                     |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                                                          |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                                                          |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                     |  |                                                                                                                                          |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M. Isabelle MacGregor MD</i>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>D13657</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 28, 1995</b>                                                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>M. ISABELLE MACGREGOR, KESWICK, 700 W. 40TH STREET, BALTIMORE, MD 21211</b>                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                     |  |                                                                                                                                          |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 32. SIGNATURE OF REGISTRAR<br><i>John A. ...</i>                                                                                                                                                    |  |                                                                                                                                          |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                            |  |                                                                                                                                                    |  |                                                             |  |                                                                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARTHA I. McCoy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 26, 1995</b>                                                                                         |  |                                                             |  | 3. TIME OF DEATH<br><b>1:43 AM M</b>                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214 34 3121</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br><b>1 M 2 F</b>                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.                                                                                                   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>SEPT. 7, 1921</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>WEST VIRGINIA</b>                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>983 R20FIELD ROAD APT. E</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BELAIR</b>                                                                                               |  |                                                             |  | 9c. COUNTY OF DEATH<br><b>HARFORD</b>                                                            |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                            |  |                                                                                                                                                    |  |                                                             |  |                                                                                                  |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br><b>HARFORD</b>                                                              |  | 10c. CITY, TOWN OR LOCATION<br><b>BELAIR</b>                                                                                                       |  |                                                             |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>                                                    |  |
| 10e. STREET AND NUMBER<br><b>983 R20FIELD ROAD APT. E.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                            |  | 10f. ZIP CODE<br><b>21014</b>                                                                                                                      |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>              |  |                                                                                                  |  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify:        |  |                                                             |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                       |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 5+) <b>AT Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                            |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>                     |  |                                                             |  | 18b. KIND OF BUSINESS/INDUSTRY                                                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILBUR DEXTER BROWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LELA GREGORY</b>                                                                           |  |                                                             |  |                                                                                                  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DANIEL MCCOY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>983 R20FIELD ROAD APT. E BELAIR, MD. 21014</b> |  |                                                             |  |                                                                                                  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BELAIR MEMORIAL 11-28-95</b>                                 |  |                                                             |  | 20c. LOCATION — City or Town, State<br><b>BELAIR, MARYLAND</b>                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>EVANS FUNERAL CHAPEL - BELAIR, PA. 21030<br/>3 NEWPORT DRIVE FOREST HILL, MD.</b>                           |  |                                                             |  |                                                                                                  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma, left lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Coronary Insufficiency</b><br><b>Arteriosclerotic Cardiovascular Disease</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |  |                                                                                            |  |                                                                                                                                                    |  |                                                             |  | Approximate Interval Between Onset and Death<br><b>3 years</b>                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Insufficiency</b><br><b>Arteriosclerotic Cardiovascular Disease</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                            |  |                                                                                                                                                    |  |                                                             |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>                                              |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                            |  |                                                                                                                                                    |  |                                                             |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                            |  | 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>                          |  |                                                             |  |                                                                                                  |  |
| 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28b. TIME OF INJURY                                                                        |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                                                                                                          |  | 28d. DESCRIBE HOW INJURY OCCURRED                           |  |                                                                                                  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                       |  |                                                             |  |                                                                                                  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                            |  |                                                                                                                                                    |  |                                                             |  |                                                                                                  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kermit P. Bonovich MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                            |  | 29c. LICENSE NUMBER<br><b>D05593</b>                                                                                                               |  |                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov. 27, 1995</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. KERMIT P. BONOVICH 754 HICKORY AVE. BELAIR, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                            |  |                                                                                                                                                    |  |                                                             |  |                                                                                                  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                    |  |                                                             |  |                                                                                                  |  |

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BALTIMORE, MARYLAND 21215-0020

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Item 1, Film 730, 12/1/95, 1t

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REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES KENNETH MORRIS</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 29 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 3. TIME OF DEATH<br><b>1:44 P<sup>M</sup></b>                                                                                                                                                                                                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-20-3641</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                       |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>SEPT. 12, 1925</b>                                                                                                                                                                                                                        |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1712 W. LOMBARD STREET</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                             |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                  |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                                                                                                           |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10e. STREET AND NUMBER<br><b>1712 W. Lombard Street</b>                                                                                                                                                                                                                             |  |
| 10f. ZIP CODE<br><b>21223</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES<br><b>WW II</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Drywall Finisher</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>                                                                                                                                                                                                                               |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Morris</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Irene Merson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Alice Mae Morris</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4719 Pennington Ave. Baltimore, MD 21226</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 12/01/95</b>                                         |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George E. MacNabb</b>                                                                                                                                                                                                               |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MIXED DRUG INTOXICATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  |                                                                                                                                                                                                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO               |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>FOUND 11-29-95</b>                                                                                                  |  | 28b. TIME OF INJURY<br><b>1:30 P<sup>M</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                         |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>SUBJECT INGESTED DRUGS</b>                                                                                                                                                                                                                                                                                                                                                           |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND AT HOME</b>                                                   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1712 W. LOMBARD STREET BALTIMORE, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dennis J. Chute MD</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 30, 1995</b>                                                                                                                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DENNIS J. CHUTE MD 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><b>Johi Anderson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                     |  |





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Robert S. Messmer Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                       |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 24 1995                                                                                                                                              |  | 3. TIME OF DEATH<br>3:30 A.M.                                                                                                                                                          |  |
| 4. SOCIAL SECURITY NUMBER<br>217 50 7767                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                                        |  | 6. AGE (In yrs. last birthday)<br>46 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Sept. 1, 1949                                                                                                                                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                       |  | 9a. FACILITY NAME (If not institution, give street and number)<br>900 Rose Anne Road                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Glen Burnie                                                                                                                                     |  |
| 9c. COUNTY OF DEATH<br>Anne Arundel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                       |  | 10a. STATE<br>Maryland                                                                                                                                                                              |  | 10b. COUNTY<br>Anne Arundel                                                                                                                                                            |  |
| 10c. CITY, TOWN OR LOCATION<br>Glen Burnie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                       |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br>900 Rose Anne Road                                                                                                                                           |  |
| 10f. ZIP CODE<br>21060                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                             |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Vietnam                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                       |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE -- American Indian, Black, White, etc.<br>Specify: White                                                                                                                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10th<br>College (1-4 or 5+) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                       |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Carpenter                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Construction                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Robert S. Messmer Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                       |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Evelyn D. Ruff                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Linda S. Messmer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                       |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>900 Rose Anne Road Glen Burnie, Maryland 21060                                                     |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                       |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Glen Haven Memorial Park 11/27                                                                                   |  | 20c. LOCATION -- City or Town, State<br>Glen Burnie, Maryland                                                                                                                          |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                       |  | 22. NAME AND ADDRESS OF FACILITY<br>George J. Gonce Funeral Home P.A.<br>4001 Ritchie Hwy. Baltimore, Md. 21225                                                                                     |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. End stage renal failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. CAD<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation<br>3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide<br>5 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                          |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                               |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                       |  | 29c. LICENSE NUMBER<br>BD 4610475                                                                                                                                                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br>24 Nov 95                                                                                                                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR Day 11055 Little Patuxent Pkwy Columbia, Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>DEC 01 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE OFFICE OF THE  
SHERIFF OF THE COUNTY OF  
SHERBORN  
SHERBORN, ENGLAND

95 36387

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RICHARD F MORRIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 29 95</b>                                                                                                                                          |  | 3. TIME OF DEATH<br><b>10:10 PM</b>                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br><b>088-24-0832</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (in yrs. last birthday)<br><b>65 YRS.</b>                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>January 15, 1930</b>                              |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>Columbia</b>                                                                                                                                           |  | 10. COUNTY OF DEATH<br><b>Howard</b>                                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Howard County General Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 10b. COUNTY<br><b>Howard</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Columbia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 10e. STREET AND NUMBER<br><b>5060 Dry Well Court</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21045</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                              |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Korean War</b>                                                                                                                              |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Administrator Officer</b>                                                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government</b>                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Michael Morris</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Catherine McCullough</b>                                                                                                                |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patricia A. Morris (wife)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5060 Dry Well Court Columbia, Maryland 21045</b>                                            |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory Inc. Dec. 4, 1995</b>                                                                                                                                                                    |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, Maryland</b>                                                                                                                             |  | 20d. DATE<br><b>Dec. 4, 1995</b>                                                            |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>R. Clay Witzke</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leroy M. &amp; Russell C. Witzke Funeral Home<br/>1630 Edmondson Avenue Catonsville, Maryland 21228</b>                                                  |  |                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>Cardiorespiratory Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Acute Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Anemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Myelodysplasia Transfusion Resistant</b><br>Approximate Interval Between Onset and Death<br><b>3 days</b><br><b>2 weeks</b><br><b>6 months</b><br><b>6 months</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                         |  |                                                                                             |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                             |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John M. ...</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>030573</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-30-95</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jon Minford, MD 11065 Little Patuxent Parkway Columbia MD 21047</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>John ...</b>                                                                                                                                                    |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36388

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                                                                                                                                                             |                                              |                                                                                                                                                                                |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|----------------------------------|--|----------------------------------------------|----------------------------------|--|-----------------|----------------------------------|--|-----------------|----------------------------------|--|-----------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JUILA AGNES MARR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  |                                                                                                                                                                                                                                                                                             |                                              | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>29</b> YEAR <b>95</b>                                                                                                               |  | 3. TIME OF DEATH<br><b>3:35 A M</b>                                                                                                                |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 4. SOCIAL SECURITY NUMBER<br><b>579-22-3590</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |                                              | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 14, 1908</b>                                                                                        |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Carroll County General Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                                                                                                                                                             |                                              | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>                                                                                                                      |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>                                                                                                              |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                                                                                                                                                             |                                              | 10b. COUNTY<br><b>Carroll</b>                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br><b>Westminster</b>                                                                                                  |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                                                                                                                                                             |                                              | 10e. STREET AND NUMBER<br><b>1301 Green Pond Ct.</b>                                                                                                                           |  | 10f. ZIP CODE<br><b>21157</b>                                                                                                                      |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                  |                                                                                                                                                                                                                                                                                             |                                              | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES       |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                                                                                                                                                             |                                              | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                                                     |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>               |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Registered Nurse</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                                                                                                                                                             |                                              | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Self Employed</b>                                                                                                                         |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Michael Sheehan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                  |                                                                                                                                                                                                                                                                                             |                                              | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hanna Callahan</b>                                                                                                     |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Tom Marr</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                                                                                                                                                             |                                              | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1301 Green Pond Ct. Westminster, Md. 21157</b>                             |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                                                                                                                                                             |                                              | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Gdns. 12/1/95 Timonium, Md.</b>                                               |  | 20c. LOCATION — City or Town, State                                                                                                                |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                                                                                                                                                             |                                              | 22. NAME AND ADDRESS OF FACILITY<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>                                                                  |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                                                                                                                                                             |                                              |                                                                                                                                                                                |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                                                                                                                                                             |                                              |                                                                                                                                                                                |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                                                                                                                                                                                                                                             |                                              |                                                                                                                                                                                |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| <table border="0"> <tr> <td rowspan="4">                 e. <b>Empyema</b><br/>                 b. <b>Bronchopneumonia</b><br/>                 c. <br/>                 d.             </td> <td colspan="2">DUE TO (OR AS A CONSEQUENCE OF):</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td colspan="2">DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>ONE WEEK</b></td> </tr> <tr> <td colspan="2">DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>ONE WEEK</b></td> </tr> <tr> <td colspan="2">DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>ONE WEEK</b></td> </tr> </table> |                                  |                                                                                                                                                                                                                                                                                             |                                              |                                                                                                                                                                                |  |                                                                                                                                                    |  | e. <b>Empyema</b><br>b. <b>Bronchopneumonia</b><br>c.<br>d. | DUE TO (OR AS A CONSEQUENCE OF): |  | Approximate Interval Between Onset and Death | DUE TO (OR AS A CONSEQUENCE OF): |  | <b>ONE WEEK</b> | DUE TO (OR AS A CONSEQUENCE OF): |  | <b>ONE WEEK</b> | DUE TO (OR AS A CONSEQUENCE OF): |  | <b>ONE WEEK</b> |
| e. <b>Empyema</b><br>b. <b>Bronchopneumonia</b><br>c.<br>d.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | DUE TO (OR AS A CONSEQUENCE OF): |                                                                                                                                                                                                                                                                                             | Approximate Interval Between Onset and Death |                                                                                                                                                                                |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | DUE TO (OR AS A CONSEQUENCE OF): |                                                                                                                                                                                                                                                                                             | <b>ONE WEEK</b>                              |                                                                                                                                                                                |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | DUE TO (OR AS A CONSEQUENCE OF): |                                                                                                                                                                                                                                                                                             | <b>ONE WEEK</b>                              |                                                                                                                                                                                |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | DUE TO (OR AS A CONSEQUENCE OF): |                                                                                                                                                                                                                                                                                             | <b>ONE WEEK</b>                              |                                                                                                                                                                                |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                                                                                                                                                             |                                              |                                                                                                                                                                                |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                              |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                                                                                                                                                             |                                              |                                                                                                                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                              |                                                                                                                                                                                |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                             |                                  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |                                              | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                        |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                           |                                              | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                       |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                           |                                  |                                                                                                                                                                                                                                                                                             |                                              |                                                                                                                                                                                |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Lume/MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                  |                                                                                                                                                                                                                                                                                             |                                              | 29c. LICENSE NUMBER<br><b>D23023</b>                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-29-95</b>                                                                                             |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JUAN A. SURIEL, M.D. CARROLL CO GEN HOSP WESTMINSTER MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                                                                                                                                                             |                                              |                                                                                                                                                                                |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                               |                                              |                                                                                                                                                                                |  |                                                                                                                                                    |  |                                                             |                                  |  |                                              |                                  |  |                 |                                  |  |                 |                                  |  |                 |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-1000

95 36389

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN JOSEPH MAGUIRE</b>                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <b>Nov</b> DAY <b>30</b> YEAR <b>1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 3. TIME OF DEATH<br><b>5:54 AM</b>                                                                                                                                          |  |
| 4. SOCIAL SECURITY NUMBER<br><b>180-12-0870</b>                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 13, 1920</b>                                                                                                                |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson, Maryland</b>                                                                                                              |  |
| 11. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 13. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                              |  |
| 14. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                        |  | 15. COUNTY<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 17. ZIP CODE<br><b>21212</b>                                                                                                                                                |  |
| 18. STREET AND NUMBER<br><b>210 St. Dunstons Rd.</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 20. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 21. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                           |  | 23. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                     |  |
| 24. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>+3</b>                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SALES</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 26. KIND OF BUSINESS/INDUSTRY<br><b>STEEL</b>                                                                                                                               |  |
| 27. FATHER'S NAME (First, Middle, Last)<br><b>Edward Maguire</b>                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Helen Maguire</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                             |  |
| 29. INFORMANT'S NAME (Type/Print)<br><b>Mrs. M. Patricia Maguire</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>210 St. Dunstons Rd. Baltimore, Maryland 21212</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                             |  |
| 31. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Maria Cemetery 12/4/95</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                             |  |
| 33. LOCATION — City or Town, State<br><b>Towson, Maryland</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 34. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Denny Xenakis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                             |  |
| 35. NAME AND ADDRESS OF FAMILY<br><b>6500 York Rd</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ISCHEMIC HEART DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a.<br>b.<br>c.<br>d.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                             |  |
| 37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MITRAL REGURGITATION</b><br><b>COAGULOPATHY</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 38. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                           |  |
| 40. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                   |  | 41. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                             |  |
| 42. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide                                                             |  | 43. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                       |  | 44. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 45. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                  |  |
| 46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                               |  | 47. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                             |  |
| 48. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                         |  | 49. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                             |  |
| 50. SIGNATURE AND TITLE OF CERTIFIER<br><b>Francis Khoo</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 51. LICENSE NUMBER<br><b>D 30263</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 52. DATE SIGNED (Month, Day, Year)<br><b>11-30-95</b>                                                                                                                       |  |
| 53. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FRANCIS KHOO, M.D., ST. JOSEPH MED. CTR., 7620 YORK RD., TOWSON, MD. 21204</b>                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                             |  |
| 54. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 55. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36390

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                               |                                                                                                 |                                                                                                                                                                                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Joseph MANLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |                                                  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 28, 1995</b>                                                                                                                                  |                                                               | 3. TIME OF DEATH<br><b>10:25 a.m.</b>                                                           |                                                                                                                                                                                                                                                      |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-24-3779</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS. |                                                                                                                                                                                                 | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb. 1, 1928</b> |                                                                                                 | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                          |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>                                                                                                                                         |                                                               | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>                                                  |                                                                                                                                                                                                                                                      |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                               |                                                                                                 |                                                                                                                                                                                                                                                      |  |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br><b>baltimore</b>                                                                                                                                                                                                                                                                |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Middle River</b>                                                                                                                                              |                                                               | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                                                                                                                                      |  |
| 10e. STREET AND NUMBER<br><b>507 Grovethorn Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |                                                  | 10f. ZIP CODE<br><b>21220</b>                                                                                                                                                                   |                                                               | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                                                                                                                                                                      |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>46-66</b>                                                                                                                                   |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                                               | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |                                                                                                                                                                                                                                                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>State Police</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>n/a</b>                                                                                                                                                                    |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>n/a</b>                                                                                                                                                    |                                                               |                                                                                                 |                                                                                                                                                                                                                                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>David Manley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Coombs</b>                                                                                                                         |                                                               |                                                                                                 |                                                                                                                                                                                                                                                      |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Danna Jo Moody</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2105 Forestside Drive Aberdeen Md. 21001</b>                                                |                                                               |                                                                                                 |                                                                                                                                                                                                                                                      |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Baltimore National 12/1/95 Baltimore Md.</b>                                                                                                                                                             |                                                  | 20c. LOCATION — City or Town, State                                                                                                                                                             |                                                               |                                                                                                 |                                                                                                                                                                                                                                                      |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>R. Terry Connelly</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly FuneralHome of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>                                                                                  |                                                               |                                                                                                 |                                                                                                                                                                                                                                                      |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                               |                                                                                                 | Approximate Interval Between Onset and Death<br><b>5 days</b>                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hepatic Failure</b><br><b>Hepato Cellular Carcinoma</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                               |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                 |                                                               |                                                                                                 |                                                                                                                                                                                                                                                      |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |                                                  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                               |                                                               | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |                                                                                                                                                                                                                                                      |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |                                                  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |                                                               |                                                                                                 |                                                                                                                                                                                                                                                      |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                               |                                                                                                 |                                                                                                                                                                                                                                                      |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                               |                                                                                                 |                                                                                                                                                                                                                                                      |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Nimish Gosrani</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  | 29c. LICENSE NUMBER<br><b>P08257</b>                                                                                                                                                            |                                                               | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 28, 1995</b>                                 |                                                                                                                                                                                                                                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Nimish Gosrani, M.D. 9000 Franklin Square Drive, Baltimore, Maryland 21237</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                               |                                                                                                 |                                                                                                                                                                                                                                                      |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Karkell</i>                                                                                                                                                                                                                                        |                                                  |                                                                                                                                                                                                 |                                                               |                                                                                                 |                                                                                                                                                                                                                                                      |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36391

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>CORNELIA C. O'ROURKE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>NOVEMBER 25 1995</i>                                                                                                                                   |  | 3. TIME OF DEATH<br><i>2:50 A</i>                                                |                                                                                                                                                    |
| 4. SOCIAL SECURITY NUMBER<br><i>218-05-2537</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 8. AGE (In yrs. last birthday)<br><i>90</i> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>SEPT 17, 1905</i>                      |                                                                                                                                                    |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>ST. AGNES HOSPITAL</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>BALTIMORE</i>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><i>BALTIMORE CITY</i>                                     |                                                                                                                                                    |
| 10a. STATE<br><i>MARYLAND</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><i>BALTIMORE</i>                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><i>ARBUTUS</i>                                    |                                                                                                                                                    |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><i>1209 LINDEN AVENUE</i>                                                                                                                                             |  |                                                                                  |                                                                                                                                                    |
| 10f. ZIP CODE<br><i>21227</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                                                                  |  |                                                                                  |                                                                                                                                                    |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>          |                                                                                                                                                    |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><i>Elementary/Secondary (0-12) 9TH GRADE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>CASHIER</i>                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>J. J. HAINES, INC.</i>                      |                                                                                                                                                    |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>DANIEL O'ROURKE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>MARGARET HUNTER</i>                                                                                                                     |  |                                                                                  |                                                                                                                                                    |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>MISS. GERTRUDE O'ROURKE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1209 LINDEN AVENUE - ARBUTUS, MD. 21227</i>                                                 |  |                                                                                  |                                                                                                                                                    |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>NEW CATHEDRAL CEMETERY</i>                                                                                                                                                                               |  | DATE<br><i>11/29</i>                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br><i>BALTIMORE</i>                          |                                                                                                                                                    |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Louis P. Smith</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><i>HUBBARD FUNERAL HOME, INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD. 21229</i>                                                                              |  |                                                                                  |                                                                                                                                                    |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Atherosclerotic cardiovascular disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>b. Hypertension</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  | Approximate interval Between Onset and Death<br><i>4 yr.</i>                                                                                       |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Cerebrovascular accident, seizure disorder</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                                                                                                    |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                    |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                                    |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                  |                                                                                                                                                    |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                                                                                                    |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>KEWEN C. D'Youza M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><i>D76292</i>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>Nov. 29, 1995</i>                      |                                                                                                                                                    |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>KEWEN C. D'Youza, DEPT. OF MEDICINE, ST. AGNES HOSPITAL.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                                                                                                    |
| 31. DATE FILED (Month, Day, Year)<br><i>DEC 01 1995</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |                                                                                                                                                    |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

62-4-4-22-3012

95 36392

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARTHA PAULINE PLATEAU</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 30 1995</b>                                                                                                                                            |  | 3. TIME OF DEATH<br><b>1:30 A.M.</b>                                                 |                                                                                                                                                                                                                                                                         |
| 4. SOCIAL SECURITY NUMBER<br><b>220-07-5592</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>95</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JUNE 1, 1900</b>                           |                                                                                                                                                                                                                                                                         |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                         |                                                                                                                                                                                                                                                                         |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>BALTIMORE CITY</b>                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                      |                                                                                                                                                                                                                                                                         |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                                                                                                                                         |
| 10e. STREET AND NUMBER<br><b>2637 WILKENS AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21223</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |                                                                                                                                                                                                                                                                         |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>if yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |                                                                                                                                                                                                                                                                         |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>TELEPHONE OPERATOR</b>                                                                                                                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BELL COMPANY</b>                                                                                                                                               |  |                                                                                      |                                                                                                                                                                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>PAUL TREBESS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>EMMA V. THOMAS</b>                                                                                                                          |  |                                                                                      |                                                                                                                                                                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MABRY POUNCY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>801 THE OLD STATION COURT-WOODBINE, MD. 21797</b>                                               |  |                                                                                      |                                                                                                                                                                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LOUDON PARK CEMETERY</b>                                                                                                                                                                                             |  | DATE<br><b>12/2</b>                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br><b>Baltimore</b>                              |                                                                                                                                                                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jackie A. Shannon</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME, INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>                                                                                   |  |                                                                                      |                                                                                                                                                                                                                                                                         |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Rupture of Abdominal Viscus with Shock</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Generalized and Cerebral Arteriosclerosis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      | Approximate Interval Between Onset and Death<br><b>24 hours</b><br><b>20 years</b>                                                                                                                                                                                      |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                                                                                                                                         |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                                                                                                                                                         |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                      |                                                                                                                                                                                                                                                                         |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                                                                                                                                         |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                                                                                                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mr. Gallagher, MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D 01474</b>                                                                                                                                                               |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>30 Nov 95</b>                              |                                                                                                                                                                                                                                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>3455 WILKENS AVE. SUITE 300, BALTIMORE MD 21229</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                                                                                                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36393

Item 1, g-730, 12-1-95, perf. h., dk

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>William A. Calvin Powell</i>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <i>Nov</i> DAY <i>27</i> YEAR <i>1995</i>                                                                                                                             |  | 3. TIME OF DEATH<br><i>1040 A M</i>                                                                                                     |                                                                   |
| 4. SOCIAL SECURITY NUMBER<br><i>236 32 5241</i>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><i>69</i> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Mar 23 1926</i>                                                                               |                                                                   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Baltimore Veterans Hosp</i>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore City</i>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><i>N/A</i>                                                                                                       |                                                                   |
| 10a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><i>Baltimore</i>                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><i>Essex</i>                                                                                             |                                                                   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                   |
| 10e. STREET AND NUMBER<br><i>41 Glenwood Road Apt. D</i>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><i>21221</i>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>                                                                                   |                                                                   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>WWII</i>                                                                                                                                    |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                                                                 |                                                                   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>11 Years</i> College (1-4 or 5+) <i></i>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Assistant Operator</i>                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Steel Industry</i>                                                                                 |                                                                   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Joseph Powell</i>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Marie Lewis</i>                                                                                                                         |  |                                                                                                                                         |                                                                   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Mrs. Mildred C. Powell</i>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>41 Glenwood Road Apt. D Essex, Maryland 21221</i>                                           |  |                                                                                                                                         |                                                                   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Nicholson Chapel Cem. 12/2/95</i>                                                                                                                                                                        |  | 20c. LOCATION — City or Town, State<br><i>Morgantown, WV</i>                                                                                                                                    |  |                                                                                                                                         |                                                                   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott Pearson</i>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, MD 21222</i>                                                                         |  |                                                                                                                                         |                                                                   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  | a. <i>Myocardial Infarct</i>                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                                                                         | Approximate Interval Between Onset and Death<br><br><i>27 yrs</i> |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | b. <i>Coronary Artery Disease</i>                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | c. <i>Hypertension</i>                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | d. <i></i>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                           |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                                                                   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><i>M</i>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                             |                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                            |                                                                   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>N. Steinkamp MD</i>                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><i>MR0793</i>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>Nov 27, 1995</i>                                                                              |                                                                   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>NANETTE STEINKAMP MD UAH, 10 N Greene St Balto. Md 21201</i>                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                   |
| 31. DATE FILED (Month, Day, Year)<br><i>DEC 01 1995</i>                                                                                                                                                                                                                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br><i>John Brinkman-Randall</i>                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36394

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>STANLEY W. POLINSKY</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH <b>Nov</b> DAY <b>29</b> YEAR <b>1995</b>                                                                                                                             |  | 3. TIME OF DEATH<br><b>10:50 pm</b> M                                                                                                               |  |
| 4. SOCIAL SECURITY NUMBER<br><b>046-09-8958</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JUNE 10, 1918</b>                                                                                         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>CONNECTICUT</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b>                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson, Maryland</b>                                                                                      |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | RESIDENCE OF DECEDENT                                                                                                                                                                           |  |                                                                                                                                                     |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br><b>Monkton</b>                                                                                                                                                   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                     |  |
| 10e. STREET AND NUMBER<br><b>16440 J.M. PEARCE ROAD</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10f. ZIP CODE<br><b>21111</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                      |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>W.W-II</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                                                                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 YRS.</b>                                                                                                                                                                                                                                                                                                                 |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>JANITOR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>TOWN OF MANCHESTER CONNECTICUT</b>                                                                                                                         |  |                                                                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unknown</b>                                                                                                                             |  |                                                                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William S. Polinsky</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16440 J.M. PEARCE ROAD Monkton, MD 21111</b>                                                |  |                                                                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GREEN MOUNT CEMETERY 1951</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>                                                                                                                               |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John Brown</b>                                                                                      |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>EVANS CHAPEL OF CHIMES<br/>2325 YORK ROAD - Timonium</b>                                                                                                                                                                                                                                                                                                                              |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPTIC SHOCK</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PROSTATE CANCER</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                               |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                         |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br><b>D 37254</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/30/95</b>                                                                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BOON P. LIM, MD 7620 YORK ROAD TOWSON, MARYLAND 21204</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                 |  |                                                                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36395

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES Preston Sr</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>28</b> YEAR <b>1995</b>                                                                                                                             |  | 3. TIME OF DEATH<br><b>0845 A.M.</b>                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-38-2618</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 6. AGE (In yrs. last birthday)<br><b>53</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug 15, 1942</b>                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>md</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto</b>                                         |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10a. STATE<br><b>md</b>                                                                                                                                                                         |  |                                                                                             |  |
| 10b. COUNTY<br><b>NIA</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>                                                                                                                                                     |  |                                                                                             |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10e. STREET AND NUMBER<br><b>3034 Normount ct.</b>                                                                                                                                              |  |                                                                                             |  |
| 10f. ZIP CODE<br><b>21216</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                                                                                   |  |                                                                                             |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify <b>Black</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>NIA</b> College (14 or 5+) <b>NIA</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Truck Driver</b>                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Balto city Public works</b>                            |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Samuel Preston</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Virginia Rice</b>                                                                                                                       |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Irene Preston</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3034 Normount ct Balto, md 21216</b>                                                        |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Mem Pk 12/4/95</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><b>Arbutus, md</b>                                                                                                                                       |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gala March</b>                              |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Mark F. H. West<br/>4300 Wabash Ave</b>                                                                                                                                                                                                                                                                                                                                               |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis with Serratia Marcescens</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Cellulitis RIGHT THIGH</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Diabetic Ulcers BOTH FEET</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Long Standing diabetes</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>End Stage renal failure. Ischemic cardiomyopathy. Emphysema. Hypertension</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  | 29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 29b. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. N. M. Machirani ATTENDING Physician</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 29c. LICENSE NUMBER<br><b>D16200</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-28-95</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. N. M. MACHIRANI 720-CMAIDEN CHOICE LA, 21228</b>                                                                                                                                                                                                                                                                               |  | 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 32. REGISTRAR'S SIGNATURE<br><b>Juli Anderson</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Edward Ross</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>21</b> YEAR <b>1995</b>                                                                                                                        |  | 3. TIME OF DEATH<br><b>2:25 a.m.</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-14-8658</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 2, 1925</b>                                                                                                                                                                                                                                                                                                                                                                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New Jersey</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>North West Hospital</b>                                                                                                    |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Randallstown</b>                                                                                                                                                                                                                                                                                                                                                                      |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                   |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Randallstown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>9109 Liberty Road</b>                                                                                                                                                                                                                                                                                                                                                                              |  |
| 10f. ZIP CODE<br><b>21133</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                           |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                  |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES <b>WWII</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5 Years</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Carpenter</b>                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Steel Industry</b>                                                                                                                                                                                                                                                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles A. Iksis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Vera Schmidt</b>                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Warren E. Ross</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>332 Drew Street Baltimore, Maryland 21224</b>                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cem. 11/27/95</b>                                                                        |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                               |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Johnny H. Hilde</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, MD 21222</b>                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Septicemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Dementia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>3 weeks</b><br><b>years</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  | 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>A. Janni MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D46263</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 21 1995</b>                                                                                                                                                                                                                                                                                                                                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Shuckler-Randall</b>                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALBERT L. RADECKE</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>25</b> YEAR <b>1995</b>                                                                                                                                                                                                                                   |  | 3. TIME OF DEATH<br><b>1038 A.M.</b>                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-16-6055</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.                                                                                                                                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 24, 1923</b>                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Johns Hopkins Bayview</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                   |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>7921 St. Bridget Lane</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                  |  | 10f. ZIP CODE<br><b>21222</b>                                                                                                                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                      |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>9th grade</b>                                                                                                                                                                                                                                                                                                     |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Industrial Mechanic</b>                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Copper Refinery</b>                                                                                                                                                                                                                                                   |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Anthony Radecke</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Catherine Kochanowski</b>                                                                                                                                                                                                                          |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Concetta M. Radecke (wife)</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7921 St. Bridget Lane, Baltimore, MD 21222</b>                                                                                                                                                         |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holly Hill Memorial Gardens</b>                                            |  | 20c. DATE<br><b>11/29</b>                                                                                                                                                                                                                                                                                  |  | 20d. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Schimunek Funeral Homes, Inc.</b><br><b>9705 Belair Rd., Baltimore, MD 21236</b>                                                                                                                                                                                    |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  | a. <b>Right Hip Pathologic Fracture</b>                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | Approximate Interval Between Onset and Death<br><b>4 months</b>                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  | b. <b>Metastatic Lung Carcinoma</b>                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 17 months                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | c. <b>Lung Carcinoma</b>                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 7 years                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | d.                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Old Myocardial Infarction</b><br><b>S/p Right Pneumectomy</b>                                                                                                                                                                                                                                       |  |                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                           |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                                                                                                                                   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Damien A. Route 'mo, Resident Physician</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>D47233</b>                                                                                                                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/25/95</b>                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Damien A. Route 'mo, Johns Hopkins Bayview Medical Center</b><br><b>4940 Eastern Ave Bldg 12 MD 21224</b>                                                                                                                                                                                                                              |  |                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                              |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36398

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FREDERICK HARRY ROBINSON, III</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>26</b> , YEAR <b>1995</b>                                                                                                                      |  | 3. TIME OF DEATH<br><b>1300</b> M                                                               |                                                                                                                                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br><b>219-28-5906</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/7/31</b>                                           |                                                                                                                                                                                                                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>7710 MIDDLESEX PLACE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>PARKVILLE</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                         |                                                                                                                                                                                                                                                             |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>PARKVILLE</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                                                                                                                                             |
| 10a. STREET AND NUMBER<br><b>7710 MIDDLESEX PLACE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21234</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                                                                                                                                                                             |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1949</b>                                                                                                                                    |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |                                                                                                                                                                                                                                                             |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th GRADE</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>GARAGE ATTENDANT</b>                                                                                                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>STATE OF MARYLAND</b>                                                                                                                                      |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FREDERICK H. ROBINSON, JR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELLA O'NEILL</b>                                                                                                                        |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ELLA V. ROBINSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7710 MIDDLESEX PLACE PARKVILLE, MD 21234</b>                                                |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH</b>                                                                                                                                                                                     |  | DATE<br><b>11/29/95</b>                                                                                                                                                                         |  | 20c. LOCATION — City or Town, State<br><b>PARKVILLE, MD</b>                                     |                                                                                                                                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>                                                                                          |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 23. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate interval Between Onset and Death<br><b>4 days</b>                                                                                                                                                                                               |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |                                                                                                                                                                                                                                                             |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>J. Crossan O'Donovan, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D07632</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-27-95</b>                                          |                                                                                                                                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. CROSSAN O'DONOVAN, 2112 DUNDALK AVE., BALTO MD 21222</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                   |  |                                                                                                 |                                                                                                                                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36399

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARGARET W. ROY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 29 1995</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 3. TIME OF DEATH<br><b>9:30 AM</b>                                                                                                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-12-0723</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>82 YRS.</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JULY 7, 1913</b>                                                                                                                             |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Mercy Hospital</b>                                                                                                                                                                                                                                                                                                                                          |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                |  |
| 9c. COUNTY OF DEATH<br><b>n/a</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>n/a</b>                                                                                                                                                              |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>2527 Harlem Avenue</b>                                                                                                                                    |  |
| 10f. ZIP CODE<br><b>21216</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>High School</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Clerical Worker</b>                                                                                                                                                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>State of Maryland Dept. of Unemployment</b>                                                                                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Amos Wilkins</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillie</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Americus M. Roy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2303 Wheatley Drive Apt. 202 Balto, MD 21207</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park Dec 4 Baltimore County, MD</b>                                                                                                                                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Herbert E. Hunter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls Parkway<br/>Baltimore, Maryland 21216</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Ischemic Bowel</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Atherosclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Approximate Interval Between Onset and Death<br><b>10 hours</b><br><b>35 years</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Abdominal Aortic Aneurysm, GID Stage Renal Disease, Coronary Artery Disease</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert C. Greenwell MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 29c. LICENSE NUMBER<br><b>D34334</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 29 1995</b>                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>315 N. CALVERT ST. Baltimore, MD 21202</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. Anderson-Rodak</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36400

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Janet H. Rattenbury</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>29</b> YEAR <b>1995</b>                                                                                                                        |  |                                                                                  |  | 3. TIME OF DEATH<br><b>Est. 8:15 PM</b>                                                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>163 30 1085</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 6, 1934</b>                      |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington</b>                                                                           |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>4302 Conifer Ct.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Arm</b>                                                                                                                                          |  |                                                                                  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                 |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Arm</b>                                                                                                                                                  |  |                                                                                  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><b>4302 Conifer Ct.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><b>21057</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                            |  |                                                                                                                                         |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |                                                                                                                                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Domestic</b>                                |  |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harris Haycox</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Irene Mathison</b>                                                                                                                      |  |                                                                                  |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William H. Rattenbury</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4302 Conifer Ct., Glen Arm, MD 21057</b>                                                    |  |                                                                                  |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Thomas Run Church Cemetery 12/2/95</b>                                                                    |  | 20c. LOCATION — City or Town, State<br><b>Bel Air, MD</b>                        |  |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSER<br><i>Stephen D. Lohrmann</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>CAFA Stephen D. Lohrmann P.A.<br/>8717 Green Pastures Dr., Baltimore, MD 21286</b>                                                                       |  |                                                                                  |  |                                                                                                                                         |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Colon Carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |  | Approximate Interval Between Onset and Death<br><b>5 years</b>                                                                          |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                               |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                       |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Man D. Sokolow</i> Attending Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  | 29c. LICENSE NUMBER<br><b>D26534</b>                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/30/95</b>                                                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><b>Man D. Sokolow, MD 3015 St. Paul Place Baltimore MD 21202</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.




IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36401

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CECILIA CATHERINE RICE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                          |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 29, 1995</b>                                                                                                                                  |  | 3. TIME OF DEATH<br><b>1:00 P. M.</b>                                                                                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-09-0935</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                               |  | 8. AGE (In yrs. last birthday)<br><b>90</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-31-05</b>                                                                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Stella Maris Hospice</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                 |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                          |  | 10c. CITY, TOWN OR LOCATION<br><b>White Marsh</b>                                                                                                                                               |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><b>6 Raylon Dr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                          |  | 10f. ZIP CODE<br><b>21236</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cook</b>                                                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Domestic Service</b>                                                                                                                                       |  |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>(unk.)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>(unk.)</b>                                                                                                                              |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Carl Bart</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                          |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7762 Notley Rd. Pasadena, MD 21122</b>                                                      |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Redeemer 12-2-95</b>                                                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>                                                                                                                                     |  |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                          |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cyach/Rosedale Funeral Home<br/>1211 Chesaco Ave.</b>                                                                                                    |  |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC ADENOCARCINOMA, UNKNOWN 1°</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  | Approximate interval Between Onset and Death<br><b>4 mos.</b>                                                                           |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                          |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                                                         |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                          |  | 29c. LICENSE NUMBER<br><b>D25643</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>12/29/95</b>                                                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36402

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |                                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Pearl Barksdale Singleton                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 27, 1995                                                                                                                                             |  | 3. TIME OF DEATH<br>9:12 A M                                                                                                                                                           |                                                                                                                                                        |
| 4. SOCIAL SECURITY NUMBER<br>216-20-6839                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br>93 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>April 19, 1902                                                                                                                                  |                                                                                                                                                        |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  | 9a. FACILITY NAME (If not institution, give street and number)<br>3714 Barrington Road                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                                                                                                                       |                                                                                                                                                        |
| 9c. COUNTY OF DEATH<br>n/a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  | 10a. STATE<br>Maryland                                                                                                                                                                              |  | 10b. COUNTY<br>n/a                                                                                                                                                                     |                                                                                                                                                        |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br>3714 Barrington Road                                                                                                                                         |                                                                                                                                                        |
| 10f. ZIP CODE<br>21215                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |                                                                                                                                                        |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                                                                                                       |                                                                                                                                                        |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) High School College (1-4 or 5+) College                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Psychiatric Aide                                                                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br>University of Maryland                                                                                                                               |                                                                                                                                                        |
| 17. FATHER'S NAME (First, Middle, Last)<br>Eugene Chase                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Josephine Fisher                                                                                                                               |  |                                                                                                                                                                                        |                                                                                                                                                        |
| 19a. INFORMANT'S NAME (Type/Print)<br>Frances Barksdale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3714 Barrington Road Baltimore, MD 21215                                                           |  |                                                                                                                                                                                        |                                                                                                                                                        |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Arbutus Memorial Park NOV 30                                                                                     |  | 20c. LOCATION — City or Town, State<br>Baltimore County, MD                                                                                                                            |                                                                                                                                                        |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Herbert E. Nutter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  | 22. NAME AND ADDRESS OF FACILITY<br>Nutter Funeral Homes, Inc.<br>2501 Gwynns Falls Parkway<br>Baltimore, Maryland 21216                                                                            |  |                                                                                                                                                                                        |                                                                                                                                                        |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Probable Myocardial Infarction<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Peripheral vascular disease<br>c. Cerebral vascular disease<br>d. |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        | Approximate Interval Between Onset and Death                                                                                                           |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |                                                                                                                                                        |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                   |                                                                                                                                                        |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                                                                                                        |                                                                                                                                                        |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |                                                                                                                                                        |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Therance Lamonte Dabno                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br>D37223                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 30 <sup>th</sup> 1995                                                                                                                  |                                                                                                                                                        |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Therance Lamonte Dabno Liberty Medical Center, Baltimore, MD 21215                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                                                                                                        |                                                                                                                                                        |
| 31. DATE FILED (Month, Day, Year)<br>DEC 01 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br>John B. Stuckert                                                                                                                                                       |  |                                                                                                                                                                                        |                                                                                                                                                        |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36403

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Charlotte W. Shervington                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV 28 1995                                                                                                                                                 |  | 3. TIME OF DEATH<br>2 30 A M                                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br>220-18-9817                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             | 6. AGE (In yrs. last birthday)<br>87 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>Oct 8, 1908                                                                                                                                                |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Union Memorial Hospital                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City                                                                                                                                             |  | 9c. COUNTY OF DEATH<br>n/a                                                                          |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br>n/a                                                                                                                                                                                                                                                                                         |                                           | 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                          |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>6608 Copper Ridge Drive                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |                                           | 10f. ZIP CODE<br>21209                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                                 |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4                                                                                                                                                                                                                                                                                                          |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Teacher                                                                                                                                                                                      |                                           | 16b. KIND OF BUSINESS/INDUSTRY<br>Baltimore City Public Sch                                                                                                                                       |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Walter Watson                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Julia Pye                                                                                                                                    |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Carol Wright                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6608 Copper Ridge Drive Baltimore Maryland 21209                                                 |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Entombment                                                                                                                                                                       |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Woodlawn Cemetery Dec 1                                                                                                                                                                                                 |                                           | 20c. LOCATION — City or Town, State<br>Baltimore County, MD                                                                                                                                       |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Kevin Parker                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |                                           | 22. NAME AND ADDRESS OF FACILITY<br>Nutter Funeral Homes, Inc.<br>2501 Gwynns Falls Parkway<br>Baltimore, Maryland 21216                                                                          |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| Pneumonia                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Decabro Vascular Accident, Angina, renal failure                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                           | 28b. TIME OF INJURY<br>M                                                                                                                                                                          |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE NOW INJURY OCCURED                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |                                           | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                            |  |                                                                                                     |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Jose CASTRO, M.D.                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |                                           | 29c. LICENSE NUMBER<br>AT2438946                                                                                                                                                                  |  | 29d. DATE SIGNED (Month, Day, Year)<br>November, 28 1995                                            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Jose Castro, M.D. 201 East University Parkway, Baltimore, MD 21218                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                   |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br>DEC 01 1995                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |                                           | 32. REGISTRAR'S SIGNATURE<br>John Shuster                                                                                                                                                         |  |                                                                                                     |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WAYNE SCOTT STEVENS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                       |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>26</b> , YEAR <b>1995</b>                                                                                                                      |  | 3. TIME OF DEATH<br><b>9:40 AM</b>                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-76-5194</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                            |  | 6. AGE (In yrs. last birthday)<br><b>22</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>5/24/73</b>                                        |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                       |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>N/B I-83 BELOW BELFAST ROAD EXIT PARKTON</b>                                                                               |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                         |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                       |  | 10c. CITY, TOWN OR LOCATION<br><b>PARKTON</b>                                                                                                                                                   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1307 MOLESWORTH ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                       |  | 10f. ZIP CODE<br><b>21120</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                          |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12th GRADE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>COOK</b>                                                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BOWLING ALLEY KITCHEN</b>                                                                                                                                  |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EDWARD W. STEVENS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                       |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>IRENE R. YIENGER</b>                                                                                                                    |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>EDWARD W. STEVENS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                       |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1307 MOLESWORTH ROAD PARKTON, MD 21120</b>                                                  |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY MEM. GAR. 11/29/95 COCKEYSVILLE, MD</b>                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Christina E. Kopych</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                       |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>                                                                                          |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE INJURIES</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ROADWAY</b> |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                         |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>11/26/95</b>                                                                                                                                                                                                                                                          |  | 28b. TIME OF INJURY<br><b>0830 AM</b>                                                                                                                                                           |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>PRINER OF AUTO VS FIXED OBJECT COLLISION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>                                                                                                                                                                                                               |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>I-8 N/B, BELFAST RD EXIT, PARKTON MD</b>                                                                     |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                       |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 27, 1995</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARIO F. GLOVE JR MD 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text at the bottom of the page, possibly a signature or date.

95 36405

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                             |  |                                                                                                 |                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Orville D. Stewart Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 30 1995</b>                                                                                                                               |  | 3. TIME OF DEATH<br><b>4:05 A.M.</b>                                                            |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>217 01 3871</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                            |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.                                                                                                                                            |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 23, 1916</b>                                    |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Oklahoma</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian Nursing Home Hammonds Ln.</b>                                                                                 |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                         |                                                                                                       |
| 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | RESIDENCE OF DECEDENT                                                                                                                                                                       |  |                                                                                                 |                                                                                                       |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>5508 Ballman Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21225</b>                                                                                                                                                               |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |                                                                                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (8-12)</b><br><b>12th</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Steam Fitter</b>                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Baltimore Gas &amp; Electric</b>                                                                                                                       |  |                                                                                                 |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Virgle Stewart</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bessie Vaughn</b>                                                                                                                   |  |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ida M. Stewart</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5508 Ballman Avenue Baltimore, Maryland 21225</b>                                       |  |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>                                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State<br><b>12/2 Baltimore, Maryland</b>                                                                                                                      |  | 20d. DATE                                                                                       |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>C. Richard Gonce</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>George J. Gonce Funeral Home P.A.<br/>4001 Ritchie Hwy. Baltimore, Md. 21225</b>                                                                     |  |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                             |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>10 yrs</b>                                         |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>OLD STROKE<br/>HYPERTENSION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                             |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                             |  |                                                                                                 |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                             |  |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                             |  |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                     |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                      |  |                                                                                                 |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                |  |                                                                                                 |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                             |  |                                                                                                 |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Attending</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D 21776</b>                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/30/95</b>                                          |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 28) (Type, Print)<br><b>SUNYA MURDER MY 1600 CRAIN AVE #106 GLENBURNIE MD 2106</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                             |  |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                             |  |                                                                                                 |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEC 11 1955



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                               |  |                                                                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>COY R. STOUT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 28, 1995</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>4:20 PM</b>                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br><b>244 03 9003</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.                                                                                                                                              |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 14, 1913</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>719 Middlesex Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Essex</b>                                                                                                                                           |  | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>                                                  |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>                                                                                                                                                   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>719 Middlesex Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                           |  | 10f. ZIP CODE<br><b>21221</b>                                                                                                                                                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                              |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Stocker</b>                                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Steel Company</b>                                                                                                                                        |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Richard Stout</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Virginia Kilby</b>                                                                                                                    |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rosa Stout</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>719 Middlesex Road Essex, Maryland 21221</b>                                              |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holly Hill Mem. Gardens 12/1/95 Baltimore Co., Maryland</b>                                                                                                                                                         |  | 20c. LOCATION — City or Town, State                                                                                                                                                           |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bruzdinski Funeral Home P.A.<br/>1407 Eastern Ave Baltimore Maryland 21221</b>                                                                                                                                                                                     |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d.</b> |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                    |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N                                                                                     |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                         |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                        |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Paul A. Valli MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                           |  | 29c. LICENSE NUMBER<br><b>P26835</b>                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/30/95</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Paul A Valli MD 1012 Mt. Pt. Rd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                               |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>11/30/95</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><i>Johi Anderson-Robert</i><br><b>DEC 01 1995</b>                                                                                                                                                                                                                            |  |                                                                                                                                                                                               |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36407

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                              |                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Jack Surret</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                               |  | 2. DATE OF DEATH<br>MONTH <u>NOV</u> DAY <u>29</u> YEAR <u>1995</u>                                                                                                                             |  | 3. TIME OF DEATH<br><u>7:45A</u> M                                           |                                                                                                                                         |
| 4. SOCIAL SECURITY NUMBER<br><u>234-12-7801</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                    |  | 6. AGE (In yrs. last birthday)<br><u>88</u> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>10-09-07</u>                       |                                                                                                                                         |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>BON SECOUR HOSPITAL</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                               |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>BALTIMORE</u>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><u>N/A</u>                                            |                                                                                                                                         |
| 10a. STATE<br><u>MD.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                               |  | 10b. COUNTY<br><u>N/A</u>                                                                                                                                                                       |  | 10c. CITY, TOWN OR LOCATION<br><u>BALTIMORE</u>                              |                                                                                                                                         |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                               |  | 10e. STREET AND NUMBER<br><u>520 S. CAROLINE STREET</u>                                                                                                                                         |  |                                                                              |                                                                                                                                         |
| 10f. ZIP CODE<br><u>21231</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                               |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                                                                     |  |                                                                              |                                                                                                                                         |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><u>UNK</u>                                                                                                                               |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>WHITE</u>      |                                                                                                                                         |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>UNK</u><br>College (1-4 or 5+) <u>UNK</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>IRON WORKER</u>                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>UNITED WORKS OF AMERICA</u>                                                                                                                                |  |                                                                              |                                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>INK</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                               |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>UNK</u>                                                                                                                                 |  |                                                                              |                                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>FRED GRANT</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                               |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>861 PARK AVENUE BALTIMORE, MD. 21202</u>                                                    |  |                                                                              |                                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                               |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>MT. ZION CEMETERY 12-01-95</u>                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><u>LANSDOWNE, MD.</u>                                                                                                                                    |  | 20d. DATE<br><u>12-01-95</u>                                                 |                                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                               |  | 22. NAME AND ADDRESS OF FACILITY<br><u>ALBERT P. WYLIE F/H PA</u><br><u>638 N. GILMOR STREET 21217</u>                                                                                          |  |                                                                              |                                                                                                                                         |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>ACUTE MYOCARDIAL INFARCTION 1 Hr</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                              | Approximate Interval Between Onset and Death                                                                                            |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></u>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                              | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                              | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                           |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                          |  | 28b. TIME OF INJURY<br><u>M</u>                                              |                                                                                                                                         |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                         |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                              |                                                                                                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                               |  | 29c. LICENSE NUMBER<br><u>027838</u>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>NOV. 29/1995</u>                   |                                                                                                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>JOHN SHAVERS, 518 CAMP MEADE RD. LINTHICUM, MARYLAND 21090</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                              |                                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><u>DEC 01 1995</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                               |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                   |  |                                                                              |                                                                                                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6878, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-7243-510

B.K.S

ITEM: 23 PART I, PER MEO FILM G-731 1/22/96 t.t

95 36408

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES MICHAEL STICHEL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 28, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>5:57 P M</b>                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-90-7437</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>32</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 20, 1963</b>                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOPKINS BAYVIEW MEDICAL CENTER</b>                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                               |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>Baltimore County</b>                                                                                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>7409 Alvah Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21222</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>10th Grade</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Roofing Company</b>                                                                                                                                        |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Robert Stichel, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Frances Irene Fogerty</b>                                                                                                               |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Frances Irene Stichel</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5019 East Oliver Street, Baltimore, Maryland 21205</b>                                      |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corporation</b>                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><b>Towson, Maryland</b>                                                                                                                                  |  | 20d. DATE<br><b>12/1/95</b>                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Kathleen M. Murphy</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John C. Miller, Inc.</b><br><b>6415 Belair Road, Baltimore, Maryland 21206</b>                                                                           |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <del>Acute Cocaine</del> Intoxication</b><br><b>NARCOTIC</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11/27/95</b>                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>2102P M</b>                                                                                                                                                           |  | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>subject overexposed on drug</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)<br><b>street</b>                                                                                                                                                                                        |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>Baltimore, Md</b>                                                                                            |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dennis J. Chute MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>O.C.M.E</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 30, 1995</b>                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DENNIS J. CHUTE MD</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020





95 36410

ITEMS1, 20b&amp;c, G-730, 12-1-95, perf. h, dk

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |                                                                                                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><del>RAYMOND DOUGLAS STORM</del> RAYMOND DOUGLASS STORM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 30 1995                                                                                                                                 |  | 3. TIME OF DEATH<br>5:25 a.m.                                                                                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br>218-05-9828                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>75 YRS.                                                                                                                                              |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>February 20, 1920                                                                                         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 9a. FACILITY NAME (If not institution, give street and number)<br>GREATER BALTIMORE MEDICAL CENTER                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>TOWSON                                                                                                       |  |
| 9c. COUNTY OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 10a. STATE<br>Maryland                                                                                                                                                                 |  |                                                                                                                                                     |  |
| 10b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br>Cockeysville                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                    |  | 10e. STREET AND NUMBER<br>21 Gibbons Boulevard                                                                                                      |  |
| 10f. ZIP CODE<br>21030                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                    |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                                                                                                                                                                                                                           |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4 or 5+) N/A                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Carpenter                          |  |
| 16b. KIND OF BUSINESS/INDUSTRY<br>Commercial & Residential                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 17. FATHER'S NAME (First, Middle, Last)<br>William Henry Storm, Sr.                                                                                                                                                                                                                                        |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Emma Eleanor Long                                                                                                                 |  |                                                                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Donna Jo Harris                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3229 Haven Beach Way Las Vegas, NV 89117                                                                                                                                                                  |  |                                                                                                                                                                                        |  |                                                                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION<br>DULANEY VALLEY MEM. GARDENS Dec 2/95                                                                                                                                                                                                                                 |  | 20c. LOCATION<br>TIMONIUM Baltimore, Maryland                                                                                                                                          |  |                                                                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Bryan W. Clary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br>Lemmon Funeral Home of Dulane Valley, Inc.<br>10 W. Padonia Road Timonium, MD 21093                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |                                                                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Recurrent Ventricular Tachycardia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. CHF<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. CAD<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |                                                                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Renal Failure, Severe, Hepatic Dysfunction, COPD.                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |                                                                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                     |  |                                                                                                                                                                                        |  |                                                                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |                                                                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                        |  |                                                                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                           |  |                                                                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |                                                                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>M. Ali Khan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 29c. LICENSE NUMBER<br>D14754                                                                                                                                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br>11-30-95                                                                                                                                        |  |                                                                                                                                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>M. ALIKHAN, M.D. O'Deg Medical Building Suite 308 Towson MD 21204                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |                                                                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br>DEC 01 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |                                                                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours of death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36411

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELENE THOMPSON</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 30 1995</b>                                                                                                                                            |  | 3. TIME OF DEATH<br><b>10:15 A M</b>                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-12-3481</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                                                                        |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec 2, 1910</b>                                           |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>629 Wilson Ave</b>                                                                                                              |  |                                                                                                     |  |
| 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                             |  |                                                                                                     |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>629 Wilson Ave</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  | 10f. ZIP CODE<br><b>21224</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                         |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                    |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Assembly Worker</b>                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Western Electric</b>                                                                                                                                           |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Schriefer</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Dorothy Hilmer</b>                                                                                                                          |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Juanita Dickerson</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>622 S. 47th Street Baltimore, Md 21224</b>                                                      |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>                                                                                                                                                                                               |  | DATE<br><b>12-1</b>                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, Md</b>                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Anthony Colt Connelly</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home of Dundalk<br/>7110 Sollers Point Rd 21222</b>                                                                                         |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Possible Acute MI</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| b. <b>4 1/2 yrs OLD CVA (Stroke)</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| c. <b>4 1/2 yrs Dementia</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| d.                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| Approximate Interval Between Onset and Death<br><b>1 hr.</b><br><b>3-4 yrs</b><br><b>3-4 yrs.</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                     |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Tarique A. Firozvi</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br><b>D14221</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11.30.95</b>                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Tarique A. Firozvi, M.D. 223 Eastern Blvd. Baltimore, Md 21221</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Anderson</b>                                                                                                                                                  |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7110 Soliers Point Rd  
Connelly Funeral Home  
12-1

llly

95-36412

FilmG. 730, item #16b, 12/01/95, cyw, per f.h.  
 1 - FOR STATE REGISTRAR  
**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 |                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Joseph H. Taylor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |                                                  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 29, 1995</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 3. TIME OF DEATH<br><b>1:00 P. M.</b>                                                           |                                                                                                                                         |
| 4. SOCIAL SECURITY NUMBER<br><b>238-64-6619</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 6. AGE (In yrs. last birthday)<br><b>55</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>4-26-1940</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>N.C.</b>                                         |                                                                                                                                         |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Irvington Knolls N/H</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                               |                                                                                                                                         |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 |                                                                                                                                         |
| 10a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                                                                                                                   |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                         |
| 10e. STREET AND NUMBER<br><b>153 S. Hilton Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |                                                  | 10f. ZIP CODE<br><b>21229</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                                   |                                                                                                                                         |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>C</b>                                                                                                                                                                                                                     |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |                                                                                                                                         |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th grade</b> College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |                                                  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Surveyor</b>                                                                                                                                                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>S T V S T B Group</b>                                      |                                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Jeffro Taylor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Georgia Leak</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                 |                                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William Taylor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>153 S. Hilton Street Baltimore, Md 21229</b>                                                                                                                                                                                                                                                                             |  |                                                                                                 |                                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Staten Memorial Cemetery 12395</b>                                                                                                                                                                    |                                                  | 20c. LOCATION — City or Town, State<br><b>Neck, Scotland, N. C.</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                 |                                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Dale March</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F/H West<br/>4300 Wabash Avenue Balto, Md 21215</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                 |                                                                                                                                         |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>AIDS</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a.<br>b.<br>c.<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Stroke</b> |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>2 Day</b><br><b>1 mo</b>                                                             |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 |                                                                                                                                         |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 |                                                                                                                                         |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |                                                                                                                                         |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |                                                  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                 |                                                                                                                                         |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |                                                  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                 |                                                                                                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Sankaran md</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |                                                  | 29c. LICENSE NUMBER<br><b>221649</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-30-95</b>                                          |                                                                                                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SAMANDAY BASKARAN 3455 Wilkens Ave, Baltimore, MD 21229</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 |                                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |                                                  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 |                                                                                                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELIZABETH P. TAYLOR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 28 1995</b>                                                                                                                                       |  |                                                                                      |  | 3. TIME OF DEATH<br>M<br><b>1:10 P</b>                                                                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>023-10-5915</b><br><b>023-10-5515</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>39</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Oct. 26, 1906</b>                       |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>NH</b>                                                                                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Lorien Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Columbia</b>                                                                                                                                              |  |                                                                                      |  | 9c. COUNTY OF DEATH<br><b>Howard</b>                                                                                                                   |  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>Howard</b>                                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Columbia</b>                                                                                                                                                      |  |                                                                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><b>6334 Cedar Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21044</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                          |  |                                                                                                                                                        |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |                                                                                                                                                        |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 8+) <b>None</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Administrative Assistant</b>                                                                                                                                                           |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Education</b>                                                                                                                                                  |  |                                                                                      |  |                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>(Unknown) Pitkin</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Josephine Ball</b>                                                                                                                          |  |                                                                                      |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elisabeth A. Larson (Daughter)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9774 Polished Stone, Columbia, MD 21046</b>                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory Nov. 29, 1995</b>                                                                                                                                                                                    |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, Maryland</b>                                                                                                                                 |  |                                                                                      |  |                                                                                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leroy M &amp; Russell C Witzke Funeral Homes</b><br><b>5555 Twin Knolls Road Columbia, Maryland</b>                                                          |  |                                                                                      |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASPIRATION PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>SWALLOWING DISORDER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>PRIOR CEREBRAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | Approximate Interval Between Onset and Death<br><b>3 DAYS</b><br><b>2 MONTHS</b><br><b>2 MONTHS</b>                                                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)                                                                                                                                                                                                                     |  |                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                    |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>DZ9909</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 28 1995</b>                       |  |                                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SCOTT MAUCKER MD 9501 OLD ANNAPOLIS RD FLEMING CITY MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                       |  |                                                                                      |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

95 36414

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Richard Underwood

2. Date of Death

November 30, 1995

3. Time of Death

3:52am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3518 Williamsburg Road

4b. City, Town, or Location of Death

Davidsonville

4c. County of Death

Anne Arundel

5. Social Security Number

218-56-9353

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

42

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 29, 1953

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Davidsonville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3518 Williamsburg Road

10f. Zip Code

21035

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Plumbing

17. Father's Name (First, Middle, Last)

Paul

Underwood

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Collins

19a. Informant's Name/Relationship (Type, Print)

Delores Christine Underwood

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3518 Williamsburg Road, Davidsonville, MD 21035

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lakemont Cemetery

Date

12/2

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Ave. Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Non-Hodgkin's Lymphoma.

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

9 mo.

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D-31650

29d. Date signed (Month, Day, Year)

11/30/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN GUTHEIL, 22 S. GREENE ST, BALTO, MD. 21201

31. Date filed (Month, Day, Year)

DEC 01 1995

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

*[Faint, illegible text, possibly bleed-through from the reverse side of the page]*

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                  |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARIE A. Wetherington</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>27</b> YEAR <b>1995</b>                                                                                                                                                                                                                                                        |  |                                                  |  | 3. TIME OF DEATH<br><b>8:40 AM</b>                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-40-2927</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>51</b> YRS.                                                                                                                                                                                                                                                                                |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                                                |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>DEC 28 1943</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                     |  |                                                  |  |                                                                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Elizabeth Home</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                         |  |                                                  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                                    |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                  |  |                                                                                                 |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                 |  |                                                  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4912 BROOKWOOD ROAD</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  | 10f. ZIP CODE<br><b>21225</b>                                                                                                                                                                                                                                                                                                   |  |                                                  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                 |  |                                                  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> <b>12</b> <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Underwriter</b>                                                                                                                                                                                             |  |                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Insurance</b>                                              |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Clifton Wetherington</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Vera R. Cirri</b>                                                                                                                                                                                                                                                       |  |                                                  |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Vera Wetherington</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>283 Hillside Terrace, Baltimore, MD 21225</b>                                                                                                                                                                               |  |                                                  |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b> <b>11/29</b>                                                                                                                                                                                                      |  |                                                  |  | 20c. LOCATION — City or Town, State<br><b>Brooklyn Park, MD</b>                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James L. Klug</i>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME, INC.</b><br><b>4107 Wilkens Ave, Baltimore, MD 21229</b>                                                                                                                                                                                                           |  |                                                  |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                  |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | a. <b>Liver Failure with Hepatic Encephulopathy</b> <b>6 days</b>                                                                                                                                                                                                                                                               |  |                                                  |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | b. <b>Cryptogenic Cirrhosis</b> <b>1/2 months</b>                                                                                                                                                                                                                                                                               |  |                                                  |  |                                                                                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | c.<br>d.<br>                                                                                                                                                                                                                                                                                                                    |  |                                                  |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                  |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                              |  |                                                  |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                  |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                  |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                      |  |                                                                                                                                              |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                                       |  | 28b. TIME OF INJURY<br><b>M</b>                  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                               |  |                                                  |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                          |  |                                                  |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                    |  |                                                  |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                  |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John A. Heath</i>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | 29c. LICENSE NUMBER<br><b>D35626</b>                                                                                                                                                                                                                                                                                            |  |                                                  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 28, 1995</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John A. Heath</b> <b>3320 Benson Ave. Baltimore MD</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                  |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Heath</i>                                                                                                                                                                                                                                                                               |  |                                                  |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.


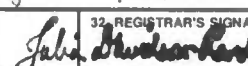
|                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Opal Virginia Wenker</b>                                                                                                                                                                                                                                    |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 30, 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 3. TIME OF DEATH<br><b>5:15 A</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>234 32 6475</b>                                                                                                                                                                                                                                                            |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                    |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 1, 1917</b>                                                                                                                                                                                                                                              |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1229 Bayside Road</b>                                                                                                                                                                                                                                                                                                                                          |  |
| 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Essex</b>                                                                                                                                                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                            |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                 |  |
| 10e. STREET AND NUMBER<br><b>1229 Bayside Road</b>                                                                                                                                                                                                                                                         |  | 10f. ZIP CODE<br><b>21221</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                     |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                 |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                    |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machine Operator</b>                                                                                                                                                                                                                                                                                            |  |
| 16b. KIND OF BUSINESS/INDUSTRY<br><b>Western Electric</b>                                                                                                                                                                                                                                                  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>George Rowe</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Stella Ratliff</b>                                                                                                                                                                                                                                                                                                                                                          |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Howard F. Wenker</b>                                                                                                                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1229 Bayside Road Essex, Maryland 21221</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |  |
| 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holly Hill Mem. Gardens 12/4/95</b>                                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore County, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                       |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Bruzdinski Funeral Home P.A.<br/>1407 Eastern Ave Baltimore, Maryland 21221</b>                                                                                                                                                                                     |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Liver Failure</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Cirrhosis Liver</b><br><b>Myelodysplasia</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  | Approximate Interval Between Onset and Death<br><b>6 months</b><br><b>5 months</b><br><b>9 months</b>                                                                                                                                                                                                                                                                                                                               |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                               |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                              |  |
| 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Myo MD</b>                                                                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br><b>D18487</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/30/95</b>                                                                                                                                                                                                                                                                                                                                                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MYO THANT 9101 FRANKLIN SQUARE DRIVE, BALTO, MD 21231</b>                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |

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95 36417

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                              |                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                 |                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DONNA ANN WARD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                              | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>25</b> YEAR <b>1995</b>                                                                                                                                                                                                                       |                                                                                                                                                                                                 | 3. TIME OF DEATH<br><b>5:50A</b> M                                                                                  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-44-6023</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                   | 6. AGE (In yrs. last birthday)<br><b>48</b> YRS.                                                                                                                                                                                                                                               | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 23, 1947</b>                                                                                                                                     | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                         |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                              | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                                   |                                                                                                                                                                                                 | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                   |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                              |                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                 |                                                                                                                     |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10b. COUNTY<br><b>Baltimore</b>                                                                                                              | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>                                                                                                                                                                                                                                                    |                                                                                                                                                                                                 | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                     |
| 10e. STREET AND NUMBER<br><b>15 Woody Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                              | 10f. ZIP CODE<br><b>21221</b>                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                 | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                               |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                                                                                                                                                                                                                                                                                | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                                                                                                     |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                              |                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                 |                                                                                                                     |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 Years</b> College (1-4 or 5+) <b>Nurse</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                              | 16. KIND OF BUSINESS/INDUSTRY<br><b>Medical</b>                                                                                                                                                                                                                                                |                                                                                                                                                                                                 |                                                                                                                     |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harry Shaw Berry</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                              | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Betty Mary Albright</b>                                                                                                                                                                                                                |                                                                                                                                                                                                 |                                                                                                                     |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Thomas W. Ward</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                              | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15 Woody Road Essex, Maryland 21221</b>                                                                                                                                                    |                                                                                                                                                                                                 |                                                                                                                     |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                              | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery 11/28/1995</b>                                                                                                                                                                         |                                                                                                                                                                                                 | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                              | 22. NAME AND ADDRESS OF FACILITY<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, MD 21222</b>                                                                                                                                                                        |                                                                                                                                                                                                 |                                                                                                                     |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>hypoxia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Neutropenia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Leukemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Leukemia</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |                                                                                                                                              |                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                 | Approximate Interval Between Onset and Death<br><b>6 days</b><br><b>2 weeks</b><br><b>6 weeks</b><br><b>8 weeks</b> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>hypernatremia congestive heart failure</b><br><b>Renal Failure</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                              |                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO               |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                              |                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                 |                                                                                                                     |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                              |                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                 |                                                                                                                     |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                              | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                 |                                                                                                                     |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                              | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                         |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                              | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |                                                                                                                                                                                                 |                                                                                                                     |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                            |                                                                                                                                              |                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                 |                                                                                                                     |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Daniel George MS medical oncology</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                              | 29c. LICENSE NUMBER<br><b>64704</b>                                                                                                                                                                                                                                                            |                                                                                                                                                                                                 | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/28/95</b>                                                              |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Daniel George MS medical oncology J-HH 600 N Wolfe St Baltimore, MD 21287.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                              |                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                 |                                                                                                                     |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                              | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                     |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36418

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FORREST M WOOD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 30th 1995</b>                                                                                                                                          |  | 3. TIME OF DEATH<br><b>12:35 AM</b>                                                                 |                                                                                                           |
| 4. SOCIAL SECURITY NUMBER<br><b>278 05 6879</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 24, 1913</b>                                          |                                                                                                           |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CLEN BURNIE</b>                                                                                                                                           |  | 9c. COUNTY OF DEATH<br><b>A.A. COUNTY</b>                                                           |                                                                                                           |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br><b>Riviera Beach</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                           |
| 10e. STREET AND NUMBER<br><b>247 Harlem Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21122</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                      |                                                                                                           |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>World War II</b>                                                                                                                                    |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |                                                                                                           |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Rigger</b>                                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Bethlehen Steel</b>                                                                                                                                            |  |                                                                                                     |                                                                                                           |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Alvin Wood</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ethel Molen</b>                                                                                                                             |  |                                                                                                     |                                                                                                           |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marilyn Zaucha</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3531 Third Street Baltimore, Maryland 21225</b>                                                 |  |                                                                                                     |                                                                                                           |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 11/30</b>                                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                                   |  |                                                                                                     |                                                                                                           |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>George J. Gonce Funeral Home P.A.<br/>4001 Ritchie Hwy. Baltimore, Md. 21225</b>                                                                             |  |                                                                                                     |                                                                                                           |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ruptured Thoracic Aortic Aneurysm</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death                                                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial Fibrillation Coronary Artery Disease</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |                                                                                                           |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D36256</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 30/1995</b>                                           |                                                                                                           |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOSE M. RANIREZ, M.D., 7845 OAKWOOD ROAD, #106/CLEN BURNIE, MARYLAND 21061</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


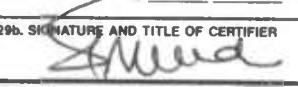
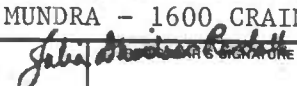
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36419

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FANNIE B. WHITESELL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>29</b> YEAR <b>1995</b>                                                                                                                                                                                                                                                                                                                                                         |  | 3. TIME OF DEATH<br><b>5:15 P. M.</b>                                                                                                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>226-10-7079</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                 |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>SEPT 20, 1915</b>                                                                                                                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>CATON MANOR NURSING HOME (MERIDIAN)</b>                                                                                                                                                                                                                                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                        |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>4122 ANNAPOLIS ROAD - APT 2-B</b>                                                                                                                         |  |
| 10f. ZIP CODE<br><b>21227</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH GRADE</b> College (1-4 or 5+) <b>SEAMSTRESS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LONDON FOG INC.</b>                                                                                                                                                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>UNKNOWN BANAKER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>UNKNOWN SMITH</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CHARLES M. WHITESELL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4122 ANNAPOLIS ROAD - APT-2-B - BALTIMORE, MD 21227</b>                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HILLTOP SERVICE CORPORATION 12/1</b>                                                                                                                                                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br><b>TOWSON</b>                                                                                                                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b><br>Approximate Interval Between Onset and Death <b>48 HRS</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>ASPIRATION</b><br>Approximate Interval Between Onset and Death <b>48 HRS</b><br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b> |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> <b>Attending</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D 21776</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/30/95</b>                                                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. SURYA P. MUNDRA - 1600 CRAIN HIGHWAY - SUITE 106 - GLEN BURNIE, MD. 21061</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b><br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


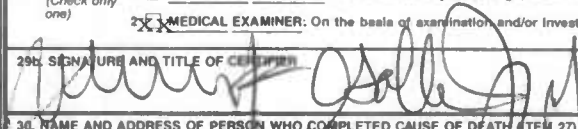
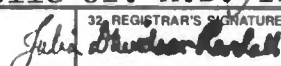
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DONALD JOSEPH WILKE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 25 1995</b>                                                                                                                                                                                                                                                  |  | 3. TIME OF DEATH<br><b>10:45 PM</b>                                                                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-36-6776</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS.                                                                                                                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 20, 1939</b>                                                                                                                             |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>4228 MT. CARMEL</b>                                                                                                                                                                                                                   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Upperco</b>                                                                                                                                  |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                        |  |
| 10c. CITY, TOWN OR LOCATION<br><b>UPPERCO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                        |  | 10e. STREET AND NUMBER<br><b>4228 Mt. Carmel Rd.</b>                                                                                                                                   |  |
| 10f. ZIP CODE<br><b>21155</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                                                                                                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>n/a</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Computer Specialist</b>                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Federal Government (Social Security)</b>                                                                                                          |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Wilke</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mildred Catherine Gumpert</b>                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Susan P. Wilke</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 9146, Naples, FL 33941</b>                                                                                                                                                                    |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 29 NOV</b>                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, MD</b>                                                                                                                          |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon Funeral Home of Dulaney Valley, Inc.<br/>10 W. Padonia Rd., Timonium, MD 21093</b>                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARBON MONOXIDE INTOXICATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>XX YES 2 <input type="checkbox"/> NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11/25/95</b>                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br><b>unknown</b>                                                                                                                                                  |  |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>CARBON MONOXIDE POSIONING</b>                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>HOME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>4228 MT. CARMEL Baltimore Maryland</b>                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                    |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 25, 1995</b>                                                                                                                            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><b>Mario F. Golle Jr. M.D. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36421

Item20b 12-6-95 FilmG730 W.H.Per F/H

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES WILLIAMS SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>29</b> YEAR <b>1995</b>                                                                                                                                                                                                                                                                                                                                                          |  | 3. TIME OF DEATH<br><b>2259</b> M                                                               |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-36-7387</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                       |  | 6. AGE (In yrs. last birthday)<br><b>55</b> YRS.                                                                                                                                                                                                                                                                                                                                                                             |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>SUG. 28, 1940</b>                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>WILMINGTON, NC</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNIV. OF MARYLAND</b>                                                                                                                                                                                                                                                                                                                                   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                         |  |
| 9c. COUNTY OF DEATH<br><b>n/a</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                  |  | 10. RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                 |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. COUNTY<br><b>n/a</b>                                                                                                                                                                                                                                                        |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>910 PENNSYLVANIA AVENUE apt. 1b</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                  |  | 10f. ZIP CODE<br><b>21201</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                           |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                     |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11 th</b> College (1-4 or 5+) <b>-</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABORER</b>                                                                                                                                                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CONSTRUCTION</b>                                           |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>OTIS WILLIAMS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BETTY</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JAMES WILLIAMS JR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>415 WATTY COURT, BALTIMORE, MD 21201</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 20b. PLACE AND DATE OF DISPOSITION (Name of place or other place)<br><b>King Park Memorial Gardens 12-2 DUNDALK, MD</b>                                                                                                                                                          |  | 20c. LOCATION — City or Town, State                                                                                                                                                                                                                                                                                                                                                                                          |  | 20d. DATE                                                                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John A. Maloney</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>STAPHYLOCOCCAL ENDOCARDITIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>AORTIC VALVE ANNULAR ABSCESS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>INFECTED PROSTHETIC AORTIC VALVE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John A. Maloney</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>046015</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 29, 1995</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DOUGLAS WALLACE ST. DEPT OF CT SUPERV. UNIV OF MARYLAND<br/>22 S. EUGENE ST. BALTIMORE, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Maloney</i>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36422

FilmG. 730. item #1. 12/01/95.cyw, per f.h.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                             |                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RALPH A. WINDER A Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>28</b> YEAR <b>95</b>                                                                                                                                                                                                                               |  | 3. TIME OF DEATH<br><b>3:35 P M</b>                                                                                                                                         |                                                                                                                                                                                                                                                                                      |
| 4. SOCIAL SECURITY NUMBER<br><b>216-20-3885</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 27, 1927</b>                                                                                                                  |                                                                                                                                                                                                                                                                                      |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Ind</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>VA Medical Center</b>                                                                                                                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                     |                                                                                                                                                                                                                                                                                      |
| 9c. COUNTY OF DEATH<br><b>NIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 10a. STATE<br><b>md</b>                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br><b>NIA</b>                                                                                                                                                   |                                                                                                                                                                                                                                                                                      |
| 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>333 Edgewood St.</b>                                                                                                                           |                                                                                                                                                                                                                                                                                      |
| 10f. ZIP CODE<br><b>21229</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                 |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |                                                                                                                                                                                                                                                                                      |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                    |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                     |                                                                                                                                                                                                                                                                                      |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>NIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Postal Clerk</b>                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Post office</b>                                                                                                                   |                                                                                                                                                                                                                                                                                      |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Alexander Winder</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Agnes Keene</b>                                                                                                                                                                                                                        |  |                                                                                                                                                                             |                                                                                                                                                                                                                                                                                      |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary E. Winder</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>333 Edgewood St Balto, Md</b>                                                                                                                                                              |  |                                                                                                                                                                             |                                                                                                                                                                                                                                                                                      |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)<br><b>Garrison Forest vet 12/24/95</b>                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, md</b>                                                                                                              |                                                                                                                                                                                                                                                                                      |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gala March</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F.H. West<br/>4300 Wabash Ave</b>                                                                                                                                                                                                                 |  |                                                                                                                                                                             |                                                                                                                                                                                                                                                                                      |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>acute renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>sepsis of unknown source</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>myelodysplasia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>1 week</b><br><b>10 days</b> |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                             | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                             |                                                                                                                                                                                                                                                                                      |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                             |                                                                                                                                                                                                                                                                                      |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                                                                                                                                             |                                                                                                                                                                                                                                                                                      |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                                                                                             |                                                                                                                                                                                                                                                                                      |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                             |                                                                                                                                                                                                                                                                                      |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Matthew Joseph Fischer MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>P08664</b>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/28/95</b>                                                                                                                      |                                                                                                                                                                                                                                                                                      |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>10 North Greene Street, Baltimore VA Medical Center, Baltimore MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                             |                                                                                                                                                                                                                                                                                      |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. H. Russell</b>                                                                                                                                                                                                                                         |  |                                                                                                                                                                             |                                                                                                                                                                                                                                                                                      |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36423

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM Patrick WRIGHT III</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>29</b> YEAR <b>1995</b>                                                                                                       |  | 3. TIME OF DEATH<br><b>6:10A</b>                                                                                                               |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-35-5492</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>3</b> YRS.                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 14, 1992</b>                                                                                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                   |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                  |  | 10b. COUNTY<br><b>Harford</b>                                                                                                                  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Belair</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                |  | 10e. STREET AND NUMBER<br><b>903 Meadowridge Court</b>                                                                                         |  |
| 10f. ZIP CODE<br><b>21014</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                 |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                        |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>Dependent</b> |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Dependent</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>                                                                                                                                   |  |                                                                                                                                                |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Patrick Wright, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Donna P. Penn</b>                                                                                                      |  |                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William Patrick Wright, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10e</b>                                                            |  |                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Belair Memorial Gardens 12/1/95 Belair, Maryland</b>                                     |  | 20c. LOCATION — City or Town, State                                                                                                            |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ronald C. Schepel</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Maryland 21204</b>                                                             |  |                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cerebral hemorrhage</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>adult respiratory distress syndrome</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Venoocclusive disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br><b>2 weeks</b><br><b>8 weeks</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                             |  |                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                    |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                   |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Stephen J. Davis MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>MP38250</b>                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/29/95</b>                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>600 N. Wolfe Street, Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John H. Ruck</i>                                                                                                                               |  |                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36424

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Edna Ellen ATWOOD</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>15</b> YEAR <b>1995</b>                                                                                                                                 |  | 3. TIME OF DEATH<br><b>10:00 A M</b>                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-18-0039</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 25, 1901</b>                         |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>920 Mulberry Avenue</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>                                                                                                                                            |  | 9c. COUNTY OF DEATH<br><b>Washington</b>                                             |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>Washington</b>                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>                                     |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 10e. STREET AND NUMBER<br><b>920 Mulberry Avenue</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21740</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                          |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>           |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>laborer</b>                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>aircraft</b>                                                                                                                                                   |  |                                                                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William A. Hawbaker</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ida Rebecca Forsythe</b>                                                                                                                    |  |                                                                                      |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Vera McAllister</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>312 Beaver Creek Rd., Hagerstown, Md. 21740</b>                                                 |  |                                                                                      |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery 11-17-95</b>                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>                                                                                                                                  |  |                                                                                      |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James L. Spicer</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME<br/>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>                                                                                      |  |                                                                                      |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  | a. <b>Cardiorespiratory arrest</b> <b>immediate</b>                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | b. <b>Ischemic heart disease</b> <b>7 YRS</b>                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | c. <b>Hypertensive heart disease</b> <b>7 YRS</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | d. <b>Coronary heart disease</b> <b>7 YRS</b>                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Massad B. Quinn</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D14880</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/95</b>                               |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>M. B. ALIZADEH, M.D. P/A<br/>245 FREDRICK STREET<br/>HAGERSTOWN, MD 21740</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 16 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36425

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                  |  |                                                                                                     |                                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PAULINE ELIZABETH ANDERSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                                  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 10, 1995</b>                                                                                                                                       |  | 3. TIME OF DEATH<br><b>6:30 P.M.</b>                                                                |                                                                                                                                                        |
| 4. SOCIAL SECURITY NUMBER<br><b>213-01-1310</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                   |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                                      |                                                                                                                                                        |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>09/06/16</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |                                                  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                      |  |                                                                                                     |                                                                                                                                                        |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>2213 Allen Drive</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>                                                                                                                                          |  | 9c. COUNTY OF DEATH<br><b>Wicomico</b>                                                              |                                                                                                                                                        |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                  |  |                                                                                                     |                                                                                                                                                        |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br><b>Wicomico</b>                                                                                                                                                                                                                                                                             |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Salisbury</b>                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                                        |
| 10e. STREET AND NUMBER<br><b>2213 Allen Drive</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |                                                  | 10f. ZIP CODE<br><b>21801</b>                                                                                                                                                                    |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                               |                                                                                                                                                        |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |                                                                                                                                                        |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Tenth</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Seamstress</b>                                                                                                                                                                            |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Shirt Factory</b>                                                                                                                                           |  |                                                                                                     |                                                                                                                                                        |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Murphy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Georgia Stevens</b>                                                                                                                      |  |                                                                                                     |                                                                                                                                                        |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert M. Anderson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2213 Allen Drive, Salisbury, MD 21801</b>                                                    |  |                                                                                                     |                                                                                                                                                        |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mardela Memorial Cem. 11-13</b>                                                                                                                                                                                      |                                                  | DATE<br><b>11-13</b>                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br><b>Mardela Springs, MD</b>                                   |                                                                                                                                                        |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Michael F. Eskow</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>Frampton-Hawkins-Eskow Funeral Home<br/>PO Box 43, Federalsburg, MD 21632</b>                                                                             |  |                                                                                                     |                                                                                                                                                        |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Breast Cancer</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Hypertension</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Diabetes</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                  |  |                                                                                                     | Approximate Interval Between Onset and Death<br><b>1990</b><br><b>1982</b><br><b>1982</b>                                                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                  |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                  |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                  |  |                                                                                                     |                                                                                                                                                        |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |                                                                                                                                                        |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |                                                  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                |  |                                                                                                     |                                                                                                                                                        |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                       |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>E. J. Colwell M.D.</b>                                                                                                                                                                                                                                         |                                                  | 29c. LICENSE NUMBER<br><b>D15081</b>                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-14-95</b>                                              |                                                                                                                                                        |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>E. J. Colwell, 540 Riverside Dr, Salisbury MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                  |  |                                                                                                     |                                                                                                                                                        |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |                                                  | 32. REGISTRAR'S SIGNATURE<br><b>John Anderson-Randall</b>                                                                                                                                        |  |                                                                                                     |                                                                                                                                                        |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36426

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                |                                                                                                                                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Leland Henry Abbott</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |                                                  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 15, 1995</b>                                                                                                                                                                                                                                                                                                                                                            |                                | 3. TIME OF DEATH<br><b>6:25 a m</b>                                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-10-6886</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                                                                                                                                                                                                                                        | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 8, 1912</b>                                                                                                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |                                                  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Mallard Bay Nursing &amp; Rehab. Center</b>                                                                                                                                                                                                                                                                                                      |                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cambridge</b>                                                                                                                        |  |
| 9c. COUNTY OF DEATH<br><b>Dorchester</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |                                                  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                | 10b. COUNTY<br><b>Dorchester</b>                                                                                                                                               |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Cambridge</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |                                                  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                       |                                | 10e. STREET AND NUMBER<br><b>200 Robbins Street</b>                                                                                                                            |  |
| 10f. ZIP CODE<br><b>21613</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |                                                  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                        |                                | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                       |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                        |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |                                                  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Estimator</b>                                                                                                                                                                                                                                                                                     |                                | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Machinery</b>                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Abbott</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nancy Willey</b>                                                                                                                                                                                                                                                                                                                                              |                                |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mildred E. Abbott</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>200 Robbins St., Cambridge, MD. 21613</b>                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |                                                  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lawn Haven Cemetery 11-17</b>                                                                                                                                                                                                                                                                                                   |                                | 20c. LOCATION — City or Town, State<br><b>Worthington, PA.</b>                                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Louis Curran Bromwell</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>Curran-Bromwell Funeral Home, P.A.<br/>308 High St., Cambridge, MD. 21613</b>                                                                                                                                                                                                                                                                                                  |                                |                                                                                                                                                                                |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer of Prostate</b><br>Approximate Interval Between Onset and Death <b>2 Years</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                            |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Insufficiency, Anemia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |                                                  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                               |                                |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |                                                  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                        |                                |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                |  |                                                                            |                                                  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                |                                | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                              |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |                                                  | 28d. DESCRIBE HOW INJURY OCCURED                                                                                                                                                                                                                                                                                                                                                                                      |                                | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                         |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Eyup Tanman MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |                                                  | 29c. LICENSE NUMBER<br><b>D14349</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/95</b>                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Eyup Tanman, M.D., 15 Franklin St., Cambridge, MD. 21613</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |                                                  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>                                                                                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36427

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Thomas Patrick Ahearn</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 15, 1995</b>                                                                                                                                                                                                                                                 |  | 3. TIME OF DEATH<br><b>7:45 P M</b>                                                                                                                                                    |                                                                                                           |
| 4. SOCIAL SECURITY NUMBER<br><b>218-70-5974</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>40</b> YRS.                                                                                                                                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Aug. 23, 1955</b>                                                                                                                         |                                                                                                           |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>308 Rosslare Drive</b>                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Arnold</b>                                                                                                                                   |                                                                                                           |
| 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><b>Anne Arundel</b>                                                                                                                                                     |                                                                                                           |
| 10c. CITY, TOWN OR LOCATION<br><b>Arnold</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                        |  | 10e. STREET AND NUMBER<br><b>308 Rosslare Drive</b>                                                                                                                                    |                                                                                                           |
| 10f. ZIP CODE<br><b>21012</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                             |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |                                                                                                           |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                                                             |                                                                                                           |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12+</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Corporate Sales Manager</b>                                                                                                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>                                                                                                                                  |                                                                                                           |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Ahearn</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Eleanor McHugh</b>                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |                                                                                                           |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Mary Ahearn</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>308 Rosslare Drive Arnold, MD 21012</b>                                                                                                                                                                |  |                                                                                                                                                                                        |                                                                                                           |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation — 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory 11-18-1995 Baltimore, MD</b>                                                                                                                                                                         |  | 20c. LOCATION — City or Town, State                                                                                                                                                    |                                                                                                           |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James E. Barranco</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Barranco &amp; Sons Funeral Home 21146<br/>495 Ritchie Hwy Severna Pk, MD</b>                                                                                                                                                                                       |  |                                                                                                                                                                                        |                                                                                                           |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Metastatic pancreatic cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        | Approximate interval Between Onset and Death<br><b>1 yr</b>                                               |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |                                                                                                           |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                        |                                                                                                           |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                        |                                                                                                           |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                 |                                                                                                           |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |  | 28h. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                           |                                                                                                           |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                            |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |                                                                                                           |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>A. C. Mawry</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 29c. LICENSE NUMBER<br><b>D44465</b>                                                                                                                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-17-95</b>                                                                                                                                 |                                                                                                           |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2) (Type, Print)<br><b>Ann C. Mawry, M.D. 900 Bestgale Rd, Annapolis, MD 21401</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |                                                                                                           |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 20 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Randall</i>                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |                                                                                                           |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

95 36428

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT ALBERT BASSETT</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 31 1995</b>                                                                                                                                                                                                                        |  | 3. TIME OF DEATH<br><b>23:50</b>                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>165 22 4834</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.                                                                                                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb. 19, 1928</b>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>                                                                                                                                                                                                                            |  | 9c. COUNTY OF DEATH<br><b>Allegany</b>                                                          |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| 10a. STATE<br><b>Pa.</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br><b>Somerset Co.</b>                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Meyersdale</b>                                                                                                                                                                                                                                    |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>RD-4</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | 10f. ZIP CODE<br><b>15552</b>                                                                                                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                     |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor</b>                                                                                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Shirt Manufacturing Co.</b>                                |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Albert Bassett</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ellen Smith</b>                                                                                                                                                                                                             |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ruth Bassett</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RD-4 Box 4B Meyersdale, Pa. 15552</b>                                                                                                                                           |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                             |  |                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>Union Cemetery Nov. 3, 1995</b>                                                                                                                                                              |  | 20c. LOCATION — City or Town, State<br><b>Meyersdale, Pa.</b>                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>William Price</i> <b>FD11249</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>William Rowe Price Funeral Home, Inc.<br/>325 Main St., Meyersdale, Pa. 15552</b>                                                                                                                                                            |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                         |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer of Prostate</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>None with this cause</b>                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                     |  |                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                                                 |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                   |  |                                                                                                 |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                        |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Renato Espina</i> <b>MD</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  | 29c. LICENSE NUMBER<br><b>120 3955</b>                                                                                                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 3, 1995</b>                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ESPINA, RENATO, M.D. 902 SETON DRIVE CUMBERLAND, MD. 21502</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 13 1995</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Andrew Karsch</i>                                                                                                                                                                                                                                |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

US

95 36429

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                                                                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Kera Eulene Verity BALLAH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                          |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 20, 1995                                                                                                                                                                                                                                                                                                                                                                             |  | 3. TIME OF DEATH<br>6:23 am. M                                                                      |                                                                                                                                                                                                                                                                 |
| 4. SOCIAL SECURITY NUMBER<br>N/A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                           |  | 6. AGE (In yrs. last birthday)<br>YRS.<br>MONTHS DAYS HOURS MIN.<br>5                                                                                                                                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>November 20, 1995 MD                                      |                                                                                                                                                                                                                                                                 |
| 8a. FACILITY NAME (If not institution, give street and number)<br>Franklin Square Hospital Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                          |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                    |  | 8c. COUNTY OF DEATH<br>Baltimore county                                                             |                                                                                                                                                                                                                                                                 |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                                                                                                                                 |
| 10a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                                                                                                                                                 |
| 10e. STREET AND NUMBER<br>9000 Franklin Square Drive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                          |  | 10f. ZIP CODE<br>21237                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                |                                                                                                                                                                                                                                                                 |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                         |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                 |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>black                                 |                                                                                                                                                                                                                                                                 |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>infant                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>infant                                                                                                                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>infant                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |                                                                                                                                                                                                                                                                 |
| 17. FATHER'S NAME (First, Middle, Last)<br>Paul Adams                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Michelle Natasha Ballah                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                     |                                                                                                                                                                                                                                                                 |
| 19a. INFORMANT'S NAME (Type/Print)<br>Hospital records                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                          |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9000 Franklin Square Drive Baltimore, MD 21237                                                                                                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                                                                                                                                 |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) hospital disposal                                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br>Franklin Square Hospital                                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br>11/30/95 Baltimore MD                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                     |                                                                                                                                                                                                                                                                 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Vicki A. Smuler/Records                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                          |  | 22. NAME AND ADDRESS OF FACILITY<br>Franklin Square Hospital Center<br>9000 Franklin Square Dr. Balto., MD 21237                                                                                                                                                                                                                                                                                                                    |  |                                                                                                     |                                                                                                                                                                                                                                                                 |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Prematurity<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death<br>5 minutes                                                                                                                                                                                                       |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                                                                                                                                 |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                                                                                                                                                 |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                          |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                     |                                                                                                                                                                                                                                                                 |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Lara Fisher MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                          |  | 29c. LICENSE NUMBER<br>P08265                                                                                                                                                                                                                                                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/20/95                                                     |                                                                                                                                                                                                                                                                 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>L. Fisher, M.D. 9000 Franklin Square Drive Baltimore, MD 21237                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                                                                                                                                 |
| 31. DATE FILED (Month, Day, Year)<br>DEC 01 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson Randall                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                     |                                                                                                                                                                                                                                                                 |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36430

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                          |                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ELIZABETH ( BETTY ) Catherine BENYO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 11, 1995                                                                                                                                                 |  | 3. TIME OF DEATH<br>5:17PM M                                                             |                                                                                                           |
| 4. SOCIAL SECURITY NUMBER<br>214 01 0629                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             | 6. AGE (In yrs. last birthday)<br>77 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 21, 1918                                                                                                                                                |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                     |                                                                                                           |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Bon Secour Extended Care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Ellicott City                                                                                                                                                |  | 9c. COUNTY OF DEATH<br>Howard                                                            |                                                                                                           |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                          |                                                                                                           |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                   |                                           | 10c. CITY, TOWN OR LOCATION<br>Catonsville                                                                                                                                                          |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                           |
| 10e. STREET AND NUMBER<br>5934 Robindale Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |                                           | 10f. ZIP CODE<br>21228                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                  |                                                                                                           |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                         |                                                                                                           |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) College                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Houswife                                                                                                                                                                                     |                                           | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                      |  |                                                                                          |                                                                                                           |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Bauer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Catherine Huppman                                                                                                                              |  |                                                                                          |                                                                                                           |
| 19a. INFORMANT'S NAME (Type/Print)<br>Sue Rottmann                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4946 Tulip Ave Balto. Md. 21227                                                                    |  |                                                                                          |                                                                                                           |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Loudon Park Cemetery 11/14 Balto. Md.                                                                                                                                                                                   |                                           | 20c. LOCATION — City or Town, State                                                                                                                                                                 |  |                                                                                          |                                                                                                           |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Stanley M. Lowener</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |                                           | 22. NAME AND ADDRESS OF FACILITY<br>Harry H. Witzke & Family Funeral Home Inc.<br>4112 Old Columbia Pike Ellicott City Md                                                                           |  |                                                                                          |                                                                                                           |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. METASTATIC BREAST CANCER<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                          | Approximate Interval Between Onset and Death<br>12 months                                                 |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                          | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                          |                                                                                                           |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                          |                                                                                                           |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                     |  |                                                                                          |                                                                                                           |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                           | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO     |                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |                                           | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)             |                                                                                                           |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                          |                                                                                                           |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Deborah Irene Pickce</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |                                           | 29c. LICENSE NUMBER<br>745931                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 13, 1995                                 |                                                                                                           |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. Deborah Irene Pickce 7220 Park Heights Ave. Balto. Md. 21208                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                          |                                                                                                           |
| 31. DATE FILED (Month, Day, Year)<br>NOV 13 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson Randall</i>                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                     |  |                                                                                          |                                                                                                           |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36431

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                         |                                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ESSIE MAE BOWIE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                       |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>15</b> YEAR <b>1995</b>           |                                                                         | 3. TIME OF DEATH<br><b>6:00 A.M.</b>                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-32-2381</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.                                                                                                                                                                                                                                                                                      |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7/5/1911</b>                       |                                                                         | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LORIEN NURSING HOME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                       |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>COLUMBIA</b>                       |                                                                         | 9c. COUNTY OF DEATH<br><b>HOWARD</b>                                                                                                    |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                         |                                                                                                                                         |  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br><b>HOWARD</b>                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>SYKESVILLE</b>                                                                                                                                                                                                                                                                                      |  |                                                                              |                                                                         | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><b>567 DEER HILL ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  | 10f. ZIP CODE<br><b>21784</b>                                                                                                                                                                                                                                                                                                         |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                               |                                                                         |                                                                                                                                         |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                       |  |                                                                              | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |                                                                                                                                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>DOMESTIC SERVICE</b>                                                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>PRIVATE HOMES</b>                       |                                                                         |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES MATTHEWS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ANNIE THOMAS</b>                                                                                                                                                                                                                                                              |  |                                                                              |                                                                         |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY KATHRYN CANBY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>567 DEER HILL ROAD SYKESVILLE, MD, 21784</b>                                                                                                                                                                                      |  |                                                                              |                                                                         |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEM. PARK</b>                                                                                                                                                                                                                                    |  | 20c. LOCATION — City or Town, State<br><b>ARBUTUS, MD.</b>                   |                                                                         |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Joseph L. Canby</i> L.F.O.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>567 DEER HILL ROAD SYKESVILLE MD. 21784</b>                                                                                                                                                                                                                                                    |  |                                                                              |                                                                         |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Cardiac arrhythmia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>High blood Pressure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Type 2 Diabetes Mellitus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Congestive heart failure</b> |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                         | Approximate Interval Between Onset and Death<br><b>Acute</b><br><b>years</b><br><b>years</b><br><b>years</b>                            |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>probable Acute Myocardial infarction</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                         | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                         | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ |  |                                                                              |                                                                         |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                |  | 28b. TIME OF INJURY<br><b>M</b>                                              |                                                                         | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                     |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) |                                                                         |                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Richard Holmberg</i>                                                                                                                                                                                                                                                                      |  | 29c. LICENSE NUMBER<br><b>D31575</b>                                         |                                                                         | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-16-95</b>                                                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Form 27) (Type, Print)<br><b>KOLDRUBETZ 9501 Old Annapolis Rd Ellicott City MD 21042</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                         |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 16 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>                                                                                                                                                                                                                                                                             |  |                                                                              |                                                                         |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Dorothy Elizabeth Bowen</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>18</b> YEAR <b>1995</b>                                                                                                                                                                                                                       |  | 3. TIME OF DEATH<br><b>12:43 P M</b>                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-05-2211</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 4, 1907</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Northampton Manor Nursing Home</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>                                                                                                                                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>                                                         |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Frederick</b>                                                                                                              |  | 10c. CITY, TOWN OR LOCATION<br><b>Mount Airy</b>                                                                                                                                                                                                                                               |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>13107 Penn Shop Rd.</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  | 10f. ZIP CODE<br><b>21771</b>                                                                                                                                                                                                                                                                  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                           |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>7</b>                                                                                                                                                                                                                                                                                                            |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>               |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>                                                                                                                                                                                                                                              |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Thomas Mount</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Crumbine</b>                                                                                                                                                                                                                      |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Linda C. Null</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11732 Warner Rd., Keymar, Md. 21757</b>                                                                                                                                                    |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Pleasant Hill Cemetery 11/21</b>                       |  | 20c. LOCATION — City or Town, State<br><b>Monrovia, Md.</b>                                                                                                                                                                                                                                    |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Chin L. Molesworth</i>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</b>                                                                                                                                                                                   |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic uterine carcinoma</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                 |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                 |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                 |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                 |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Degenerative Arthritis</b>                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                             |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                       |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ronald E. Miller</i>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | 29c. LICENSE NUMBER<br><b>026489</b>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov. 20, 1995</b>                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ronald E. Miller, M.D. 4 Culwell Drive, Mount Airy, Md. 21771</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 22 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><i>Richard Randall</i>                                                                                                                                                                                                                                            |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE S. BARE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>21</b> YEAR <b>95</b>                                                                                                                                                                                                                                                                                                                                                             |  | 3. TIME OF DEATH<br><b>8.45A M</b>                                                                                                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-09-0917</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.                                                                                                                                                                                                                                                                                                                                                                             |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 6, 1914</b>                                                                                                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>550 Washington Rd.</b>                                                                                                                                                                                                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>                                                                                                                      |  |
| 9c. COUNTY OF DEATH<br><b>Carroll</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Carroll</b>                                                                                                                                                  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Westminster</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>550 Washington Rd.</b>                                                                                                                            |  |
| 10f. ZIP CODE<br><b>21157</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII &amp; KOREAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                                                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Officer</b>                                                                                                                                                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>United States Army</b>                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Dr. Luther Bare</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nell Schaeffer</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jean Harlow Bare</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>550 Washington Rd., Westminster, MD 21157</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Krider's Church Cemetery 11/25/95</b>                                                                                                                                                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State<br><b>Westminster, MD</b>                                                                                                                  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Katherine Pitts - Sweiter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Pitts Funeral Home &amp; Chapel 412 Washington Rd., Westminster, MD 21157</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>acute myocardial infarction</b><br>Approximate Interval Between Onset and Death <b>several hours</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic severe CHF, IDDM</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                    |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>DSB along MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D23015</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/21/95</b>                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DINESH S. KALARIA 217 WASHINGTON HTCS WESTMINSTER MD 21157</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 22 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36434

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Francis Eugene Bradford                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                  |  | 2. DATE OF DEATH<br>November 18, 1995                                                                                                                                                                                                                                                                                                                                                                                        |  | 3. TIME OF DEATH<br>2:25 A M                                                                |                                                                                                                                                    |
| 4. SOCIAL SECURITY NUMBER<br>578-50-5200                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                       |  | 6. AGE (In yrs. last birthday)<br>57 YRS.                                                                                                                                                                                                                                                                                                                                                                                    |  | 7. DATE OF BIRTH<br>Feb 19, 1938                                                            |                                                                                                                                                    |
| 8. FACILITY NAME (If not institution, give street and number)<br>Fort Washington Ambulatory Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br>Fort Washington                                                                                                                                                                                                                                                                                                                                                                       |  | 9b. COUNTY OF DEATH<br>Prince George's                                                      |                                                                                                                                                    |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br>Prince George's                                                                                                                                                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br>Oxon Hill                                                    |                                                                                                                                                    |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                  |  | 10e. STREET AND NUMBER<br>6709 Livingston Road                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                             |                                                                                                                                                    |
| 10f. ZIP CODE<br>20745                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                             |                                                                                                                                                    |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                         |                                                                                                                                                    |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Master Plumber                                                                                                                                                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Heating and Cooling                                       |                                                                                                                                                    |
| 17. FATHER'S NAME (First, Middle, Last)<br>Francis George Bradford                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Alice Delores Nalley                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                             |                                                                                                                                                    |
| 19a. INFORMANT'S NAME (Type/Print)<br>Eleanor M. Bradford                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6709 Livingston Road, Oxon Hill, Md 20745                                                                                                                                                                                                                                                                                   |  |                                                                                             |                                                                                                                                                    |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Resurrection Cemetery Nov 20, 1995                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br>Clinton, Md                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                             |                                                                                                                                                    |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br>Lee Funeral Home, Inc 6633<br>Old Alexandria Ferry Road, Clinton, Md 20735                                                                                                                                                                                                                                                                                                               |  |                                                                                             |                                                                                                                                                    |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CORONARY ARTERY DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. HYPERTENSION, OBESITY<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. CARDIAC ARRHYTHMIA, CARDIAC ARREST<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>e. HYPERTENSIVE HEART DISEASE<br>f. PERIPHERAL VASCULAR DISEASE<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             | Approximate interval Between Onset and Death                                                                                                       |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |                                                                                                                                                    |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                                    |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                                             |                                                                                                                                                    |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                             |                                                                                                                                                    |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Dante V. Lee MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                  |  | 29c. LICENSE NUMBER<br>D15789                                                                                                                                                                                                                                                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br>11-18-95                                             |                                                                                                                                                    |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DANIEL G. LEE, MD<br>7700 OLD BRANCH AVE, CLINTON, MD 20735                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |                                                                                                                                                    |
| 31. DATE FILED (Month, Day, Year)<br>NOV 22 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br>John Bruckner-Rasbell                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                             |                                                                                                                                                    |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM: 4. PER F.H. FILM g-730 12/29/95 t.t

95 36435

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>TERRY JAY BOWMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 9, 1995</b>                                                                                                                                       |  | 3. TIME OF DEATH<br><b>1:35 PM</b>                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-06-5956</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>27</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>February 17, 1968</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>16105 VILLAGE DRIVE WEST</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>UPPER MARLBORO</b>                                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGES</b>                                                        |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br><b>Prince Georges</b>                                                                                                                                                                                                                                                                       |  | 10c. CITY, TOWN OR LOCATION<br><b>Upper Marlboro</b>                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>16105 Village Drive West</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>20772</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                         |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5 +)                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Skilled labor</b>                                                                                                                                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Self-Employed</b>                                                                                                                                              |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ellis S. Bowman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Agnes Griffith</b>                                                                                                                          |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Beverly Chancey</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13704 Baden Westwood Rd, Brandegee MD 20615</b>                                                 |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                       |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Resurrection Cem. 11-16-95 Clinton MD</b>                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br><b>Clinton MD</b>                                                                                                                                            |  | 20d. DATE<br><b>11-16-95</b>                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lloyd</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Adams Funeral Home, Agasson MD 20608</b>                                                                                                                     |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Gunshot wounds of Head</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>XX YES</b> 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>UNK</b>                                                                                                                                                                                                                                                       |  | 28b. TIME OF INJURY<br><b>UNK</b>                                                                                                                                                                   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject shot</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>HOME</b>                                                                                                                                                                                                      |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>16105 Village Drive West</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Carol Locke MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 10, 1995</b>                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Pittman Locke, MD 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 22 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                                                                                                                                           |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>AGNES A. BOWMAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                       |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 9, 1995                                                                                                                                              |  | 3. TIME OF DEATH<br>1:35 P.M.                                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br>214-32-8563                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                        |  | 6. AGE (In yrs. last birthday)<br>61 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>November 18, 1933                                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 9a. FACILITY NAME (If not institution, give street and number)<br>16105 VILLAGE DRIVE WEST                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>UPPER MARLBORO                                                                                                                                               |  | 9c. COUNTY OF DEATH<br>PRINCE GEORGES                                                               |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br>Prince George's                                                                                                                                                                                                                                                                                        |  | 10c. CITY, TOWN OR LOCATION<br>Upper Marlboro                                                                                                                                                       |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>16105 Village Drive West                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>20772                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                |  |                                                                                                     |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Administrator                                                                                                                                                                                           |  | 15b. KIND OF BUSINESS/INDUSTRY<br>Bd UF Education, P.G.                                                                                                                                             |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Joseph Griffith                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                       |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Agnes Proctor                                                                                                                                  |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Beverly Chancey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                       |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13704 Baden Westwood Rd, Brandywine MD 20613                                                       |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                               |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maryland Vet. Cemetery 11-16-95                                                                                                                                                                                                    |  | 20c. LOCATION (City or Town, State)<br>Cheltenham, Maryland                                                                                                                                         |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Lloyd                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                       |  | 22. NAME AND ADDRESS OF FACILITY<br>Adams Funeral Home, Aquasco MD 20608                                                                                                                            |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Gunshot Wound of Head<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY (Month, Day, Year)<br>UNK                                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>UNK                                                                                                                                                                          |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>HOME                                                                                                                                                                                                                        |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>Shot<br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>16105 Village Drive West                                               |  |                                                                                                     |  |
| 29. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>29. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>J. L. Locke MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                       |  | 29c. LICENSE NUMBER<br>O.C.M.E.                                                                                                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br>NOVEMBER 10, 1995                                            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>J. L. Locke MD 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 22 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br>John A. Russell-Randall                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |  |



95 36437

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                               |  |                                                                                             |  |                                                                                                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Elsie Mae Butler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 19, 1995</b>                                                                                                                                |  |                                                                                             |  | 3. TIME OF DEATH<br><b>10:55 p.m.</b>                                                                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-42-6503</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                              |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 26, 1939</b>                                                                                         |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>2980 Ross Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |                                                  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>St. Leonard</b>                                                                                                                                     |  |                                                                                             |  | 8c. COUNTY OF DEATH<br><b>Calvert</b>                                                                                                              |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br><b>Calvert</b>                                                                                                                                                                                                                                                                  |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>St. Leonard</b>                                                                                                                                             |  |                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><b>2980 Ross Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |                                                  | 10f. ZIP CODE<br><b>20685</b>                                                                                                                                                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                 |  |                                                                                                                                                    |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |                                                                                             |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                            |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b><br>College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Custodian</b>                                                                                                                                                                 |                                                  |                                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Board of Education</b>                                 |  |                                                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Mackall</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elsie Chase</b>                                                                                                                       |  |                                                                                             |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Brenda Butler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2980 Ross Road St. Leonard, MD 20685</b>                                                  |  |                                                                                             |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Brooks UM Church Cem. 11/25/95</b>                                                                                                                                                                       |                                                  |                                                                                                                                                                                               |  | 20c. LOCATION — City or Town, State<br><b>St. Leonard, MD</b>                               |  |                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Spencer E. Sewell</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>Sewell Funeral Home<br/>1451 Dares Beach Rd. Prince Frederick, MD</b>                                                                                  |  |                                                                                             |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate interval Between Onset and Death <b>Months</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                               |  |                                                                                             |  |                                                                                                                                                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                               |  |                                                                                             |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                               |  |                                                                                             |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                               |  |                                                                                             |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                               |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |                                                  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |  |                                                                                             |  |                                                                                                                                                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                               |  |                                                                                             |  |                                                                                                                                                    |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John W. Heigel MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                                  | 29c. LICENSE NUMBER<br><b>726358</b>                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov. 22, 1995</b>                                 |  |                                                                                                                                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOHN WIGER MD - PRINCE FREDERICK MD - 20677</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                               |  |                                                                                             |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 22 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>                                                                                                                                                                                                                                      |                                                  |                                                                                                                                                                                               |  |                                                                                             |  |                                                                                                                                                    |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36438

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Thomas Boome</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 13, 1995</b>                                                                                                                                                                                                                                 |  |                                                                                  |  | 3. TIME OF DEATH<br><b>1810</b> M                                                                                                                                                                                                                                                                                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-18-5444</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.                                                                                                                                                                                                                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                        |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 18, 1921</b>                                                                                                                                                                                                                                                                                                                                                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>                                                                                                                                                                                             |  |                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Prince Frederick</b>                                                                                                                                                                                                                                                                                                                                                               |  |
| 9c. COUNTY OF DEATH<br><b>Calvert</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                  |  |                                                                                  |  | 10b. COUNTY<br><b>Calvert</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Prince Frederick</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                |  |                                                                                  |  | 10e. STREET AND NUMBER<br><b>320 Mason Road</b>                                                                                                                                                                                                                                                                                                                                                                              |  |
| 10f. ZIP CODE<br><b>20678</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                    |  |                                                                                  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Nov. 1942--Nov. 1945</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  |                                                                                  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                                                                                                                                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>11</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>                                                                                                                                                                   |  |                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>State Highway</b>                                                                                                                                                                                                                                                                                                                                                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Randolph Boome</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Carrie Keyes</b>                                                                                                                                                                                                                       |  |                                                                                  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Angeline Boome</b>                                                                                                                                                                                                                                                                                                                                                                  |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>320 Mason Road Prince Frederick, MD 20678</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                          |  |                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MD Veterans Cemetery 11/17/95</b>                                                                                                                                                                                                                                                                                                      |  |
| 20c. LOCATION — City or Town, State<br><b>Cheltenham, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Spencer E. Sewell</b>                                                                                                                                                                                                                          |  |                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Sewell Funeral Home<br/>1451 Dares Beach Rd. Prince Frederick, MD</b>                                                                                                                                                                                                                                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Massive Left Acute and Subacute Subdural Hematoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                  |  | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                                                                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD, Alcohol Abuse</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                  |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |  |
| 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John Youssaf M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>D27189</b>                                                                                                                                                                                                                                                           |  |                                                                                  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/14/95</b>                                                                                                                                                                                                                                                                                                                                                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ZAHIR YOUSAF, P.O. BOX 1289 WALDORE, M.D. 20604</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                                                                                                                                                                                                                                      |  |                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

3+1

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36439

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                     |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Melba Hutchins Bowen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 15 1995                                                                                                                                              |  |                                                                                                                                            |  | 3. TIME OF DEATH<br>3:20 A M                                                                        |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br>217 40 0704                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 8. AGE (In yrs. last birthday)<br>86 YRS.                                                                                                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                             |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                                      |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 24 1909 |  | 8. BIRTHPLACE (State or Foreign)<br>Maryland                                                              |  |                                                                                                                                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Solomoons Nursing Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Dowell/ Solomons                                                                                                                                             |  |                                                                                                                                            |  | 9c. COUNTY OF DEATH<br>Calvert                                                                      |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                     |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br>Calvert                                                                                                                                                                                                                                                                                     |  | 10c. CITY, TOWN OR LOCATION<br>Prince Frederick                                                                                                                                                     |  |                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 10e. STREET AND NUMBER<br>5950 Sheridan Point Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>20678                                                                                                                                                                              |  |                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                                      |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |                                                                                                                                            |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                    |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>bankteller                                                                         |  |                                                                                                                                            |  | 18b. KIND OF BUSINESS/INDUSTRY<br>Banking                                                           |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Benson Croin Hutchins                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rose Buckler                                                                          |  |                                                                                                     |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Lowell R. Bowen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>17112 Old York Rd. Monkton Maryland 21111 |  |                                                                                                     |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Central Cemetery November 18 1995                                                                                |  |                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br>Bartow Cal. Maryland                                         |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>B. Brown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | 22. NAME AND ADDRESS OF FACILITY<br>Rausch Funeral Home<br>4405 Brookes Is. Rd. Port Republic Maryland 20676                               |  |                                                                                                     |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Adenocarcinoma of stomach<br>Due to (OR AS A CONSEQUENCE OF):<br>b. with Metastasis<br>Due to (OR AS A CONSEQUENCE OF):<br>c.<br>Due to (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                     |  |                                                     |  | Approximate Interval Between Onset and Death<br>4 months                                                  |  |                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Alcohol Abuse<br>Congestive Heart Failure<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                     |  |                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                     |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined                                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                   |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                        |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>A. T. Munshi MD. Attending Physician                                                                                                                                                                                                                              |  |                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br>D 19427                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/16/95                                                     |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Anwar T. Munshi, M.D. 110 Hospital Rd. Prince Frederick, Maryland 20678                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                     |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 17 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Rodall                                                                                                                                                   |  |                                                                                                                                            |  |                                                                                                     |  |                                                     |  |                                                                                                           |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36440

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RICHARD BROWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>13</b> , YEAR <b>1995</b>                                                                                                                      |  | 3. TIME OF DEATH<br><b>10:25 A M</b>                                                            |                                                                                                           |
| 4. SOCIAL SECURITY NUMBER<br><b>261-24-1342</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>Month, Day, Year<br><b>Oct. 13, 1917</b>                                    |                                                                                                           |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Fl.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 9. COUNTY OF DEATH<br><b>CECIL</b>                                                                                                                                                              |  | 10. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |                                                                                                           |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>VA MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>PERRYVILLE</b>                                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>CECIL</b>                                                             |                                                                                                           |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. COUNTY<br><b>Harford</b>                                                                                                                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br><b>Aberdeen</b>                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                           |
| 10e. STREET AND NUMBER<br><b>711 Edmund Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21001</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                           |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |                                                                                                           |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cook</b>                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Food Industry</b>                                                                                                                                          |  |                                                                                                 |                                                                                                           |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Daniel Brown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Gray</b>                                                                                                                           |  |                                                                                                 |                                                                                                           |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Brown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>711 Edmund Street, Aberdeen, Md. 21001</b>                                                  |  |                                                                                                 |                                                                                                           |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arlington Nat'l Cem. 11/20/95 Arlington, Va.</b>                                                                                                                                                         |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  | 20d. DATE<br><b>11/20/95</b>                                                                    |                                                                                                           |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Beard Funeral Home 21078<br/>552 Lewis Street, Havre de Grace, Md.</b>                                                                                   |  |                                                                                                 |                                                                                                           |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. <b>Aspiration</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br>DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>4 days</b><br><br><b>2 weeks</b><br><br><b>2 weeks</b> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Stroke-Left Occipitoparietal; Seizure Disorder;</b><br><b>Non-Insulin Dependent Diabetes; Parkinson's Disease</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                           |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                           |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                           |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                 |                                                                                                           |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                           |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>EUGENE CRAIG, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D41608</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/95</b>                                          |                                                                                                           |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print)<br><b>VAMEDICAL CENTER, PERRY POINT, MD 21902</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                           |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                           |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36441

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                      |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>IDA MAE BALDACHINO</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 17 1995</b>                                                                                                                                       |  | 3. TIME OF DEATH<br><b>12:10 a m</b>                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>153-22-2423</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/2/1909</b>                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3935 Conowingo Road</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Darlington</b>                                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>Harford</b>                                                |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                      |  |
| 10a. STATE<br><b>New Jersey</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><b>Monmouth</b>                                                                                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>Holmdel</b>                                                                                                                                                   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>5 Sweetbriar Lane</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>07733</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                                |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                                                                                                                                                              |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Own home</b>                                                                                                                                               |  |                                                                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harmon Baldachino</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Louise Herman</b>                                                                                                                       |  |                                                                                      |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mae Moyna</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3935 Conowingo Road Darlington, MD 21034</b>                                                |  |                                                                                      |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Humanity Gifts Registry</b>                                                                                                                                                                              |  | OATE                                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br><b>Phila, PA</b>                              |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jeffrey P. Lovelidge</i>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Harkins Funeral Home, Inc. Delta, PA</b>                                                                                                                 |  |                                                                                      |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                      |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart failure</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                      |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                      |  |
| a. <b>Coronary Artery Sclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>10YR</b><br>b. <b>Ischemic Myocardial Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>10YR</b><br>c. <b>And Hypertensive ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF): <b>10YR</b>                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                      |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                      |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                      |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                      |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                      |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                      |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                      |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dudley Phillips MD</i>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D09482</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/95</b>                               |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dudley Phillips, Shuresville Road, Darlington, MD 21034</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                      |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>Juba A. Hudson-Randall</i>                                                                                                                                      |  |                                                                                      |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36442

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Dorothy Lorraine Carr</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>16</b> YEAR <b>1995</b>                                                                                                       |  | 3. TIME OF DEATH<br><b>8:56 P M</b>                                                                                                          |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-28-8334</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.                                                                                                                               |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Aug. 3, 1907</b>                                                                                |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Reeders Memorial Home</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Boonsboro</b>                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>WASHINGTON</b>                                                                                                     |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Washington</b>                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Williamsport</b>                                                                                           |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>Kemps Mill Rd.</b>                                                                                                                                |  | 10f. ZIP CODE<br><b>21795</b>                                                                                                                |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                        |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>     |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Registered Nurse</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Medical</b>                                                                                                                               |  |                                                                                                                                              |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Roy Edwin Patton</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jessie Arvella Torrence</b>                                                                                            |  |                                                                                                                                              |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nancy L. Lindewurth</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box # 454 Williamsport, MD 21795</b>                                  |  |                                                                                                                                              |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenlawn Memorial Park Nov. 20, 1995</b>                                                |  | 20c. LOCATION — City or Town, State<br><b>Williamsport, MD 21795</b>                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>OSBORNE FUNERAL HOME<br/>P.O. Box # 348 Williamsport, MD 21795</b>                                                                      |  |                                                                                                                                              |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary Artery Disease</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>Arteriosclerosis Cardiovascular Disease</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>with Atrial Fibrillation</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                   |  |                                                                                                                                              |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D 18019</b>                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 17, 1995</b>                                                                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Vasant Datta 334 Mill St. Hagerstown, MD. 21740 301-739-7100</b>                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                              |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  | REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                |  |                                                                                                                                              |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36443

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ROBERT V. COCHRAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                  |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 27, 1995                                                                                                                                             |  | 3. TIME OF DEATH<br>12:45 A.M.                                                                      |                                                                                                           |
| 4. SOCIAL SECURITY NUMBER<br>215-34-6152                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                   | 6. AGE (In yrs. last birthday)<br>59 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>April 29, 1936                                                                                                                                            |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                |                                                                                                           |
| 9a. FACILITY NAME (If not institution, give street and number)<br>St. JOseph's Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                  |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson                                                                                                                                                       |  | 9c. COUNTY OF DEATH<br>Baltimore                                                                    |                                                                                                           |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                         |                                           | 10c. CITY, TOWN OR LOCATION<br>Monkton                                                                                                                                                              |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                           |
| 10e. STREET AND NUMBER<br>14512 Jarrettsville Pike                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                  |                                           | 10f. ZIP CODE<br>21111                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                             |                                                                                                           |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>1955 - 1958                                                                                                                                  |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |                                                                                                           |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Cashier - Attendant                                                                                                                                                             |                                           | 16b. KIND OF BUSINESS/INDUSTRY<br>Service Station                                                                                                                                                   |  |                                                                                                     |                                                                                                           |
| 17. FATHER'S NAME (First, Middle, Last)<br>George W. Cochran                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                  |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Thelma Garlitz                                                                                                                                 |  |                                                                                                     |                                                                                                           |
| 19a. INFORMANT'S NAME (Type/Print)<br>Jean K. Cochran                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                  |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>14512 Jarrettsville Pike, Monkton, MD 21111                                                        |  |                                                                                                     |                                                                                                           |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Reformed Church Cem. Jacksonville, Nov 30, 1995                                                                                                                                                               |                                           | 20c. LOCATION — City or Town, State<br>Jacksonville, MD                                                                                                                                             |  |                                                                                                     |                                                                                                           |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>J.J. Hartenstein</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                  |                                           | 22. NAME AND ADDRESS OF FACILITY<br>J.J. Hartenstein Mortuary, Inc.<br>24 Second St., New Freedom, PA 17349                                                                                         |  |                                                                                                     |                                                                                                           |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Acute myocardial infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>ASCD</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death<br><br>10 YRS                                                |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypertension</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DONA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                        |                                           | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |                                                                                                           |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                  |                                           | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                     |                                                                                                           |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                  |                                           | 29c. LICENSE NUMBER<br>D18822                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/27/95                                                     |                                                                                                           |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>R. HABERSAT 214 Mt CARMEL RD PARKTON, MD 21120                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 31. DATE FILED (Month, Day, Year)<br>NOV 30 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                  |                                           | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Randall</i>                                                                                                                                             |  |                                                                                                     |                                                                                                           |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


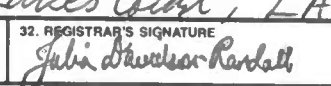
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36444

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ARCHIE BYRON CLOKEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |                                                  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>13</b> , YEAR <b>1995</b>                                                                                                                      |  | 3. TIME OF DEATH<br><b>9:45 p.m.</b>                                                            |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>220 - 12 - 9561</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br><b>99</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>02/03/1896</b>                                                                                                                                     |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                     |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>9132 Washington Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Savage</b>                                                                                                                                            |  | 9c. COUNTY OF DEATH<br><b>Howard</b>                                                            |                                                                                                       |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>Howard</b>                                                                                                                                                                                                                                                                   |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Savage</b>                                                                                                                                                    |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>9132 Washington Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |                                                  | 10f. ZIP CODE<br><b>20763</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                    |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/><br><b>1 Year</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Farmer</b>                                                                                                                                                                 |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Farm</b>                                                                                                                                               |  |                                                                                                 |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Nobel Clokey</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Charlotte Marriott Jacobs</b>                                                                                                           |  |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charlotte Watts</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 162, Savage, Maryland 20763</b>                                                    |  |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King Family Cemetery</b>                                                                                                                                                                                 |                                                  | DATE<br><b>11/16</b>                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br><b>Annapolis Junction, MD</b>                            |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707</b>                                                                             |  |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebro-Vascular Accident.</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Arteriosclerosis.</b><br>c.<br>d.<br>Approximate Interval Between Onset and Death<br><b>9 years</b> |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>old fracture left Hip.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |                                                  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                 |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Abdul Nayeem M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |                                                  | 29c. LICENSE NUMBER<br><b>D21294</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/14/95</b>                                          |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ABDUL NAYEEM, M.D.<br/>8037 - Laurel Lakes Court, LAUREL, M.D. 20707.</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 15 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |                                                  | 32. REGISTRAR'S SIGNATURE<br>                                                                                |  |                                                                                                 |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36445

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Carl Edward Collum                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 15 1995                                                                                                                                              |  | 3. TIME OF DEATH<br>1600 P M                                                                        |                                                                                                                                                        |
| 4. SOCIAL SECURITY NUMBER<br>233-48-4559                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                          | 6. AGE (In yrs. last birthday)<br>63 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>July 24, 1932                                                                                                                                             |  | 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia                                           |                                                                                                                                                        |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown                                                                                                                                                   |  | 9c. COUNTY OF DEATH<br>Washington                                                                   |                                                                                                                                                        |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br>Frederick                                                                                                                                                                                                                                                                                |                                           | 10c. CITY, TOWN OR LOCATION<br>Thurmont                                                                                                                                                             |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                                        |
| 10e. STREET AND NUMBER<br>8940B Links Bridge Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |                                           | 10f. ZIP CODE<br>21788                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                                      |                                                                                                                                                        |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |                                                                                                                                                        |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Mechanic/Maintenance                                                                                                                                                                   |                                           | 16b. KIND OF BUSINESS/INDUSTRY<br>Communication- COMSAT                                                                                                                                             |  |                                                                                                     |                                                                                                                                                        |
| 17. FATHER'S NAME (First, Middle, Last)<br>Carl William Collum                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Myrtle Irene Davisson                                                                                                                          |  |                                                                                                     |                                                                                                                                                        |
| 19a. INFORMANT'S NAME (Type/Print)<br>Dorothy Mae Collum                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8940B Links Bridge Rd., Thurmont, MD 21788                                                         |  |                                                                                                     |                                                                                                                                                        |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Resthaven Cemetery 11/18                                                                                                                                                                                             |                                           | 20c. LOCATION — City or Town, State<br>Frederick, Maryland                                                                                                                                          |  |                                                                                                     |                                                                                                                                                        |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Paul P. B. Mackay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |                                           | 22. NAME AND ADDRESS OF FACILITY<br>Stauffer Funeral Homes, P.A.<br>621 Opossumtown Pike, Frederick, MD 21702                                                                                       |  |                                                                                                     |                                                                                                                                                        |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cerebrovascular Accident</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b.<br>c.<br>d.<br>Approximate Interval Between Onset and Death<br>2 days |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Arteriosclerotic Cardiovascular Disease</u>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                           | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                       |                                           | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |                                                                                                                                                        |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |                                           | 29c. LICENSE NUMBER<br>D18019                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>Nov 16, 1995                                                 |                                                                                                                                                        |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>[Signature] VASANT DATTA MD 334 MILL ST MAG. MD                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 31. DATE FILED (Month, Day, Year)<br>NOV 22 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |                                           | 32. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                                                                            |  |                                                                                                     |                                                                                                                                                        |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36446

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                              |                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ida Hilton Chesney</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>13</b> YEAR <b>1995</b>                                                                                                                            |  | 3. TIME OF DEATH<br><b>10:50 P M</b>                                         |                                                                                                                                                        |
| 4. SOCIAL SECURITY NUMBER<br><b>212-38-3012</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                            |  | 6. AGE (In yrs. last birthday)<br><b>93</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Oct. 30, 1902</b>               |                                                                                                                                                        |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Homewood at Frederick</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>                                      |                                                                                                                                                        |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br><b>Frederick</b>                                                                                                                                                                     |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>                              |                                                                                                                                                        |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                              |                                                                                                                                                        |
| 10e. STREET AND NUMBER<br><b>31 West Patrick St.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                           |  | 10f. ZIP CODE<br><b>21701</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                        |                                                                                                                                                        |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                       |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>      |                                                                                                                                                        |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>County Schools</b>                                                                                                                                             |  |                                                                              |                                                                                                                                                        |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James J. Hilton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sarah Beall</b>                                                                                                                             |  |                                                                              |                                                                                                                                                        |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lila Cave</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1747 Redgate Farms Ct., Rockville, Md. 20850</b>                                                |  |                                                                              |                                                                                                                                                        |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Damascus Meth. 11/16/95</b>                                                                                                                                                                         |  | 20c. LOCATION — City or Town, State<br><b>Damascus, Md.</b>                                                                                                                                         |  |                                                                              |                                                                                                                                                        |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Olin L. Molesworth</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                           |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</b>                                                                                        |  |                                                                              |                                                                                                                                                        |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>pneumonia</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                              | Approximate Interval Between Onset and Death<br><b>Days</b>                                                                                            |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Artery Disease</b><br><b>Atherosclerotic Heart Disease</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                              | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                              | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                        |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                              |                                                                                                                                                        |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                         |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                        |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                              |                                                                                                                                                        |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Casper E. Cline, III, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                           |  | 29c. LICENSE NUMBER<br><b>D16428</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov. 14, 1995</b>                  |                                                                                                                                                        |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Casper E. Cline, III, M.D. 300 W 9th Street, Frederick, Md. 21701</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                              |                                                                                                                                                        |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 15 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                           |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>                                                                                                                                                  |  |                                                                              |                                                                                                                                                        |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36447

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                |  |                                                                                                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GERTRUDE COFFREN</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>15</b> , YEAR <b>1995</b>                                                                                                                                                                                                                  |  |                                                                                                                |  | 3. TIME OF DEATH<br><b>2:35 A M</b>                                                                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>038-14-5435</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.                                                                                                                                                                                                                                            |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                                               |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                                                                                                   |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Sept 25, 1927</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Paw Tucket, RI</b>                                                                                                                                                                                                                           |  |                                                                                                                |  |                                                                                                                                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Fort Washington Hospital Center</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Fort Washington</b>                                                                                                                                                                                                                               |  |                                                                                                                |  | 9c. COUNTY OF DEATH<br><b>Prince George's</b>                                                                                                      |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                |  |                                                                                                                                                    |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br><b>Charles</b>                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Waldorf</b>                                                                                                                                                                                                                                               |  |                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><b>5124 C Shawe Place</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 10f. ZIP CODE<br><b>20602</b>                                                                                                                                                                                                                                                               |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                          |  |                                                                                                                                                    |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                             |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                     |  |                                                                                                                                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Federal Government</b>                                                    |  |                                                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Murphy</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Frances Powers</b>                                                                                                                                                                                                             |  |                                                                                                                |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Cathleen A. Coffren- McSorley</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9101 Townsend Lane, Clinton, Md 20735</b>                                                                                                                                               |  |                                                                                                                |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                |  |                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery</b>                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br><b>Clinton, Maryland</b>                                                |  |                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Stanley E. Marsolais</i>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735</b>                                                                                                                                                                          |  |                                                                                                                |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                |  | Approximate Interval Between Onset and Death                                                                                                       |  |
| a. <b>CONGESTIVE HEART FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                |  | 3 YEARS                                                                                                                                            |  |
| b. <b>CORONARY ARTERY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                |  | 10 YEARS                                                                                                                                           |  |
| c.<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                |  |                                                                                                                                                    |  |
| d.<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                |  |                                                                                                                                                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>AORTIC STENOSIS</b><br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>                                                                                       |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                              |  |                                                                                                                                              |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                           |  |                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |  |                                                                                                                |  |                                                                                                                                                    |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                     |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                |  |                                                                                                                                                    |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William J Oetgen</i>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 29c. LICENSE NUMBER<br><b>D16129</b>                                                                                                                                                                                                                                                        |  |                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOVEMBER 15, 1995</b>                                                                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WILLIAM J OETGEN, MD 9131 PISCATAWAY RD #600 CLINTON, MD 20735</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 22 1995</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>                                                                                                                                                                                                                                  |  |                                                                                                                |  |                                                                                                                                                    |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

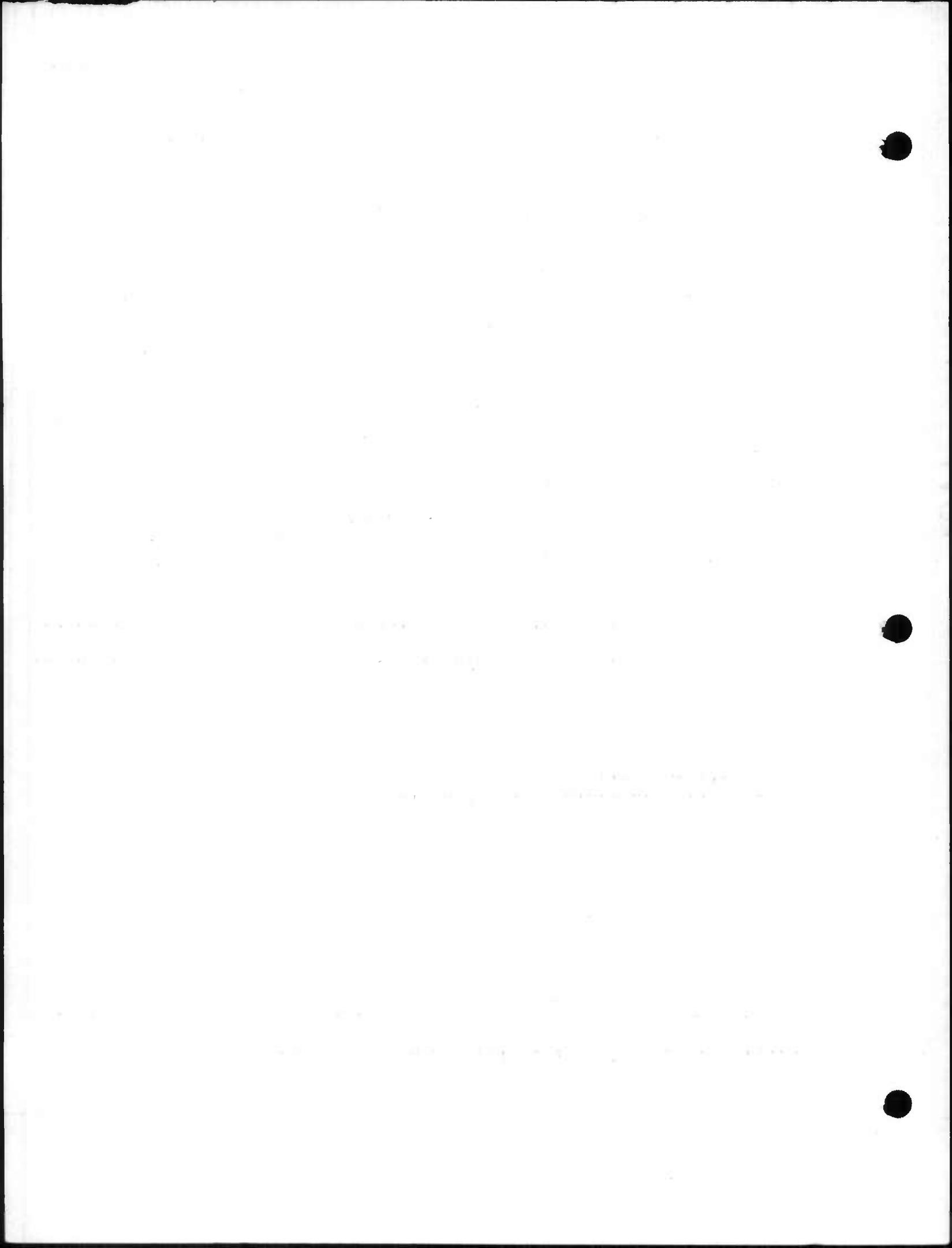
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36448

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Betty Jane Cox</i>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>November 15/95</i>                                                                                                                                     |  | 3. TIME OF DEATH<br><i>141 P M</i>                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><i>577-26-4447</i>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><i>73</i> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>May 14, 1922</i>                                |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><i>Prince George Hospital Center</i>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Cheverly</i>                                                                                                                                          |  | 9c. COUNTY OF DEATH<br><i>Prince George's</i>                                                |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| 10a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><i>Prince George's</i>                                                                                                                                                                                                                                                       |  | 10c. CITY, TOWN OR LOCATION<br><i>Cheverly</i>                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>1917 Berry Lane</i>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><i>Forestville</i>                                                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>Prince George's</i>                                      |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <i>8th</i> College (1-4 or 5+) <i></i>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Receiving Manager</i>                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Hechingers</i>                                          |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Thomas Albert Swain</i>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Elizabeth Jane Dronenburg</i>                                                                                                           |  |                                                                                              |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Barbara Lynn Bennett</i>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2711 Pinewood Drive, Waldorf, Md 20601</i>                                                  |  |                                                                                              |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Arlington National Cemetery Nov 21, 1995</i>                                                              |  | 20c. LOCATION — City or Town, State<br><i>Arlington, Virginia</i>                            |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735</i>                                                                              |  |                                                                                              |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| IMMEDIATE CAUSE (Final result in death) → <i>Hypertensive cerebral-cardiovascular disease</i>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                      |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                              |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Augusto P. Rodriguez M.D.</i>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><i>D21230</i>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>November 16, 1995</i>                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Augusto P. Rodriguez M.D. 5009 Rayburn Ct., Camp Springs, MD 20748</i>                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                              |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 22 1995</i>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                                                                                                                                       |  |                                                                                              |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

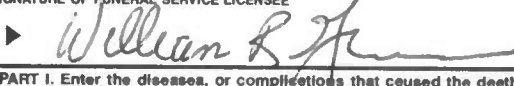
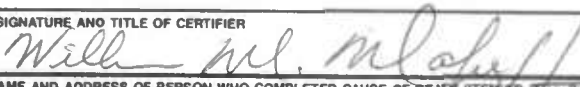
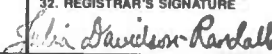
DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36449

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ralph Allen Conner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>13</b> , YEAR <b>1995</b>                                                                                                                          |  | 3. TIME OF DEATH<br><b>0324</b>                                                                     |                                                                                                           |
| 4. SOCIAL SECURITY NUMBER<br><b>577-38-4139</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-16-22</b>                                               |                                                                                                           |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Calvert Mem. Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Prince Frederick</b>                                                                                                                                      |  | 9c. COUNTY OF DEATH<br><b>Calvert</b>                                                               |                                                                                                           |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><b>Calvert</b>                                                                                                                                                                                                                                                                              |  | 10c. CITY, TOWN OR LOCATION<br><b>Huntingtown</b>                                                                                                                                                   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                           |
| 10e. STREET AND NUMBER<br><b>2531 Plum Point Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>20639</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                         |                                                                                                           |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>                                                                                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                             |                                                                                                           |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electronic Engineer</b>                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Fed. Govt.</b>                                                                                                                                                 |  |                                                                                                     |                                                                                                           |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Allen G. Conner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Wilma Chastain</b>                                                                                                                          |  |                                                                                                     |                                                                                                           |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Craig A. Conner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6120 Leitch Lane, Tracy's Landing, MD 20779</b>                                                 |  |                                                                                                     |                                                                                                           |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lakemont Mem. Gardens 11-17-95 Davidsonville, MD</b>                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br><b>MD</b>                                                                                                                                                    |  | 20d. LOCATION — City or Town, State<br><b>MD</b>                                                    |                                                                                                           |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rausch Funeral Home, P.A., Owings, MD</b>                                                                                                                    |  |                                                                                                     |                                                                                                           |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Ruptured Abdominal Aortic Aneurysm</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>DIC</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Renal Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Myocardial Infarction</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death                                                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                           |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                     |                                                                                                           |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D47443</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/95</b>                                              |                                                                                                           |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print)<br><b>Dr. William M. Mahaffey Prince Frederick, MD 20678</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                           |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


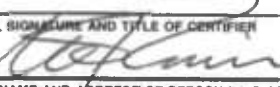
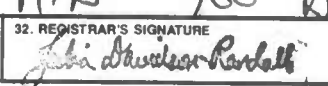




95 36450

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LORRAINE M. CHEETHAM</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 17 1995</b>                                                                                                                                       |  | 3. TIME OF DEATH<br><b>5:00 A M</b>                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>088-24-5978</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 5, 1932</b>                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>                                                          |  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br><b>Millersville</b>                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>899 Cecil Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21108</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                         |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>cashier</b>                                                                                                                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>retail</b>                                                                                                                                                     |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Casper Rozniewski</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Eleanor Richardson</b>                                                                                                                      |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Brian Cheetham</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2350 Westport Lane/Crofton MD 21114</b>                                                         |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory 11/18</b>                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><b>Alexandria VA</b>                                                                                                                                         |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Advent Funeral &amp; Cremation Services<br/>Annapolis MD 21401</b>                                                                                           |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div> <b>Chronic Obstructive Pulmonary D</b><br/> <b>EMPHYSEMA</b> </div> <div>           Approximate interval Between Onset and Death<br/> <b>4 days</b><br/> <b>Chronic</b><br/> <b>YEARS</b> </div> </div> |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                     |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>123172</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/95</b>                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S.D. KRIMINS, H.D. 900 BESTGATE RD ANNAPOLIS MD 21401</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 20 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                    |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



5 Amended Harford County Health Dept. November 20, 1995 Line 10, 10a, 10b, 10c, 10d, 10e & 10 F KDG 95, 38451, c

1 FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                    |  |                                                                         |  |                                                                                                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Mary Teresa Corcoran</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH <u>11</u> DAY <u>09</u> YEAR <u>1995</u>                                                                                                                                                                                                 |  |                                                                         |  | 3. TIME OF DEATH<br><u>4:30 a.m.</u>                                                                                                               |  |
| 4. SOCIAL SECURITY NUMBER<br><u>184-22-7797</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                      |  | 6. AGE (In yrs. last birthday)<br><u>95</u> YRS.                                                                                                                                                                                                                   |  | 7. DATE OF BIRTH<br>MONTH <u>09</u> DAY <u>14</u> YEAR <u>1900</u>      |  | 8. BIRTHPLACE (State or Foreign Country)<br><u>Philadelphia, Pa.</u>                                                                               |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Lorien - Riverside</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                 |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Belcamp, Maryland</u>                                                                                                                                                                                                    |  |                                                                         |  | 9c. COUNTY OF DEATH<br><u>Harford</u>                                                                                                              |  |
| 10a. STATE<br><u>MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                 |  | 10b. COUNTY<br><u>HARFORD</u>                                                                                                                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br><u>BELCAMP</u>                           |  |                                                                                                                                                    |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |  | 10e. STREET AND NUMBER<br><u>209 N. Belmont Ave.</u>                                                                                                                                                                                                               |  | 10f. ZIP CODE<br><u>21017</u>                                           |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                        |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                    |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |                                                                                                                                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u></u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                 |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Sewing Machine Operator</u>                                                                                                                    |  |                                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>U. S. Government</u>                                                                                          |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>(u/k) (u/k) Doyle</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Rose (nmn) McCabe</u>                                                                                                                                                                                      |  |                                                                         |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Patricia A. Fellona</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>317 Roxbury Ct., Joppa, Md. 21085</u>                                                                                                                          |  |                                                                         |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Laurel Memorial Park 11-14-95</u>                         |  | 20c. LOCATION — City or Town, State<br><u>Pomona, New Jersey</u>                                                                                                                                                                                                   |  |                                                                         |  |                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Howard K. McComas III</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                 |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Rd., Abingdon, Md 21009</u>                                                                                                                                     |  |                                                                         |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <u></u> DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u></u> DUE TO (OR AS A CONSEQUENCE OF):<br>d. <u></u> |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                    |  |                                                                         |  | Approximate Interval Between Onset and Death<br><u>3 days</u>                                                                                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Dementia</u><br><u>Hypertension</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                    |  |                                                                         |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                    |  |                                                                         |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                 |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  |                                                                         |  | 28a. DATE OF INJURY (Month, Day, Year)<br><u></u>                                                                                                  |  |
| 28b. TIME OF INJURY<br><u>M</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                        |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><u></u>                            |  |                                                                                                                                                    |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><u></u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                 |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><u></u>                                                                                                                                                                            |  |                                                                         |  |                                                                                                                                                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                     |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                    |  |                                                                         |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>John Davidson Randall</u>                                                                              |  |
| 29c. LICENSE NUMBER<br><u>H39022</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                    |  |                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>November 9 1995</u>                                                                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>PETER L. Bressa, 1308 Business Center Way, Edgewood MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                    |  |                                                                         |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><u>NOV 13 1995</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                 |  | 32. REGISTRAR'S SIGNATURE<br><u>John Davidson Randall</u>                                                                                                                                                                                                          |  |                                                                         |  |                                                                                                                                                    |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 36452

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |  |                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Billie Darrell DAVIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>19</b> YEAR <b>1995</b>                                                                                                                                                                                                                               |  | 3. TIME OF DEATH<br><b>4:15 P M</b>                                                                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>223-30-8827</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS.                                                                                                                                                                                                                                                       |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>March 30, 1929</b>                                                                                                                        |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b>                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>                                                                                                                                |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                       |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Damascus</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                        |  | 10e. STREET AND NUMBER<br><b>12010 Bethesda Church Road</b>                                                                                                                            |  |
| 10f. ZIP CODE<br><b>20872</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                                                                                                                                  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Korean</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                                                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Mechanical Engineer</b>                                                                                                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Communications</b>                                                                                                                                |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank F. Davis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Winnie Leo Crismond</b>                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ann R. Davis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12010 Bethesda Church Rd., Damascus, Md. 20872</b>                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gate of Heaven 11/24/95</b>                                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br><b>Silver Spring, Md.</b>                                                                                                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Olin L. Molesworth</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</b>                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>HEPATORENAL SYNDROME</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>CIRRHOSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>Gastrointestinal Hemorrhage</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  |                                                                            |  |                                                                                                                                                                                                                                                                                                        |  | Approximate Interval Between Onset and Death<br><b>1 wk</b><br><b>1 month</b>                                                                                                          |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  |                                                                                                                                                                                                                                                                                                        |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                            |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Nomicide 4 <input type="checkbox"/> Other                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                 |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                        |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  |                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Carl L. Schoenberg MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>D26540</b>                                                                                                                                                                                                                                                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 19 1995</b>                                                                                                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Carl L. Schoenberg 16220 Frederick Rd. Gaithersburg</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 22 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><b>Theresa Randall</b>                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELSIE MAY ECKEL</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>16</b> YEAR <b>1995</b>                                                                                                                                                                                                                       |  | 3. TIME OF DEATH<br><b>0025 A M</b>                                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-28-2753</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>January 12, 1920</b>                                                                                                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>                                                                                                                       |  |
| 9c. COUNTY OF DEATH<br><b>Washington</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><b>Washington</b>                                                                                                                                               |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>16906 Springlake Court</b>                                                                                                                        |  |
| 10f. ZIP CODE<br><b>21740</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                 |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                        |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (8-12) 8 years</b>                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Personal residence</b>                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Raymond W. Hoover</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lottie M. Forrest</b>                                                                                                                                                                                                                  |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Beverley Lee Durst</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16906 Springlake Court Hagerstown, Md. 21740</b>                                                                                                                                           |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery 11-18-1995</b>                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Douglas A. Fiery</i>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Douglas A. Fiery Funeral Home<br/>1331 Eastern Blvd. North Hagerstown, Md.</b>                                                                                                                                                                          |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                     |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiorespiratory Failure</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| b. <b>Advanced Cancer of Vagina with</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| c. <b>Metastasis to Bladder &amp; Uterus</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| d. <b>Hypertension</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. A. Fisher MD</i>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>D35497</b>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/95</b>                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>TANVIR A. KASHA MD 376 MILL ST. HAGERSTOWN MD</b>                                                                                                                                                                                                                                                                                  |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 20 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





95 36454

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |                                                         |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EARL JAMES FAITH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 17 1995                                                                                                                                          |                                                         |                                                                                             |                                                                                                 | 3. TIME OF DEATH<br>5:05p.m. <sup>M</sup>                                                                                               |  |  |
| 4. SOCIAL SECURITY NUMBER<br>220-30-9510                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br>92 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>Nov. 9, 1903                                                                                                                                             |                                                         | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                        |                                                                                                 |                                                                                                                                         |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Homewood Retirement Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Williamsport                                                                                                                                             |                                                         |                                                                                             | 9c. COUNTY OF DEATH<br>Washington                                                               |                                                                                                                                         |  |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10b. COUNTY<br>Washington                                                                                                                                                                                                                                                                      |                                           | 10c. CITY, TOWN OR LOCATION<br>Clear Spring                                                                                                                                                     |                                                         |                                                                                             | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                         |  |  |
| 10e. STREET AND NUMBER<br>13662 Faith Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                           | 10f. ZIP CODE<br>21722                                                                                                                                                                          |                                                         | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                     |                                                                                                 |                                                                                                                                         |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                                         |                                                                                             | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                             |                                                                                                                                         |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Supervisor                                                                                                                                                                       |                                           |                                                                                                                                                                                                 | 16b. KIND OF BUSINESS/INDUSTRY<br>Roads Department      |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Faith                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Cora Sword                                                                                                                                 |                                                         |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Elwood Faith                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13614 Faith Rd. Clear Spring, MD 21722                                                         |                                                         |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Little Rose Hill Nov. 21, 95                                                                                                                                                                                |                                           |                                                                                                                                                                                                 | 20c. LOCATION — City or Town, State<br>Clear Spring, MD |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |                                           | 22. NAME AND ADDRESS OF FACILITY<br>Thompson Funeral Home, Inc.<br>P.O. Box 310 Clear Spring, MD 21722                                                                                          |                                                         |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <u>Dysphagia</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Senescence of all functions</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |                                                         |                                                                                             |                                                                                                 | Approximate Interval Between Onset and Death<br>6 mths                                                                                  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Type II diabetes mellitus</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |                                                         |                                                                                             |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |                                                         |                                                                                             |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                 |                                                         |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |                                           | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |                                                         | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                 | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                       |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |                                           | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |                                                         |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |                                                         |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |                                           | 29c. LICENSE NUMBER<br>D 26579                                                                                                                                                                  |                                                         |                                                                                             | 29d. DATE SIGNED (Month, Day, Year)<br>11/18/95                                                 |                                                                                                                                         |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>R.C. Kugler 747 Northern Avenue Hagerstown, Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |                                                         |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 20 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |                                           | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                   |                                                         |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36455

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lawrence Bernard Faith</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 10 1995</b>                                                                                                                                        |  | 3. TIME OF DEATH<br><b>0832 A.M.</b>                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>186-48-7940</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>40</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 29, 1955</b>                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>University of Maryland Hospital</b>                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                         |  |
| 9c. COUNTY OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Washington</b>                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>628 Linganore Avenue</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21740</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Truck Driver</b>                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Lumber Company</b>                                                                                                                                         |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Bernard Lawrence Faith</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marie Ann Morris</b>                                                                                                                    |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Shirley H. Faith</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>628 Linganore Avenue, Hagerstown, Md. 21740</b>                                             |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rose Hill Cemetery 11-17-95</b>                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>                                                                                                                              |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>R. Neil Brady</i>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Andrew K. Coffman Funeral Home, Inc.<br/>40 E. Antietam Street, Hagerstown, Md. 21740</b>                                                                |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| a. <b>Cardiomyopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| b. <b>End Stage Renal Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| c. <b>Peritonitis</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| d.                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                         |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Gregory A. Bishop MD</i>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>P08655</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 10, 1995</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>GREGORY BISCHOP MD 22 S.Green St. Baltimore, MD 21201</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE OF DEATH (Month, Day, Year)<br><b>NOV 10 1995</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 32. REGISTRAR'S SIGNATURE<br><i>Jane [Signature]</i>                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36456

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                           |                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Edward James Frederick                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 12, 1995                                                                                                                                             |  | 3. TIME OF DEATH<br>8:00 P.M.                                                                             |                                                                  |
| 4. SOCIAL SECURITY NUMBER<br>218-09-3564                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>76 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>April 20, 1919                                                     |                                                                  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>226 West High Street                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Elkton                                                                                                                                                       |  | 9c. COUNTY OF DEATH<br>Cecil                                                                              |                                                                  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                           |                                                                  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br>Cecil                                                                                                                                                                                                                                                                                       |  | 10c. CITY, TOWN OR LOCATION<br>Elkton                                                                                                                                                               |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |                                                                  |
| 10e. STREET AND NUMBER<br>226 West High Street                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21921                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                   |                                                                  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>World War II                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                          |                                                                  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>9                                                                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Truck Driver                                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Fuel Oil Delivery                                                                                                                                                 |  |                                                                                                           |                                                                  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Frederick                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Maude Hamilton                                                                                                                                 |  |                                                                                                           |                                                                  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Doris Frederick                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>226 West High Street - Elkton, MD 21921                                                            |  |                                                                                                           |                                                                  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Bethel Cemetery                                                                                                                                                                                                         |  | 20c. LOCATION — City or Town, State<br>1995 North East, Maryland                                                                                                                                    |  |                                                                                                           |                                                                  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald S. Hicks</i>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>Hicks Home for Funerals, P.A.<br>103 W. Stockton St., Elkton, MD 21921-5521                                                                                     |  |                                                                                                           |                                                                  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                           |                                                                  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  | a. <i>Acute Myocardial Infarction</i>                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                     |  |                                                                                                           | Approximate Interval Between Onset and Death<br><i>Immediate</i> |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  | b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                           |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                           |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                           |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                           |                                                                  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                           |                                                                  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                           |                                                                  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |                                                                  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                           |                                                                  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>H. Farkas, MD</i>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>D15314                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 12, 1995                                                  |                                                                  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>H. Farkas, MD, Union Hospital, Elkton, MD 21921</i>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                           |                                                                  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 15 1995                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                                                                                                                                           |  |                                                                                                           |                                                                  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

84114

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

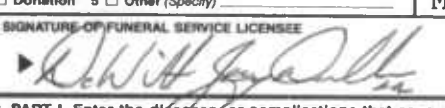
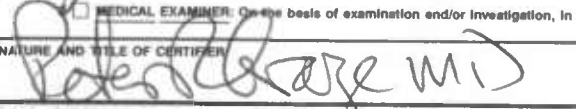
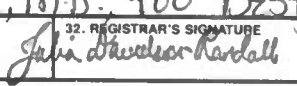
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36457

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LOIS ANN GARDNER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>11</b> YEAR <b>1995</b>                                                                                                                                                                                                                                                                                                                                                 |  | 3. TIME OF DEATH<br><b>11:05 p.m.</b>                                                                                                               |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218 - 24 - 2929</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.                                                                                                                                                                                                                                                                                                                                                                         |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 3, 1928</b>                                                                                          |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>16110 Julie Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Laurel</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 9c. COUNTY OF DEATH<br><b>Prince George</b>                                                                                                         |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10b. COUNTY<br><b>Prince George</b>                                                                                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br><b>Laurel</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                     |  |
| 10e. STREET AND NUMBER<br><b>16110 Julie Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><b>20707</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                         |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                            |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>US Department of Agriculture</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Luther Edward Bounds</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Itilda Sellers</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Janet L. Hardesty</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>33 Sands Avenue, Annapolis, Maryland 21403</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 11/13</b>                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, Maryland</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                     |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. METASTATIC RENAL CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                          |  | Approximate Interval Between Onset and Death<br><b>34RS</b>                                                                                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ASIAL FIBRILLATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                               |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                          |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                     |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                         |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                     |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>D16364</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/95</b>                                                                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Peter R. Graze, M.D. 900 Bestgate Rd #300, Annapolis, MD 21401</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 15 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

20

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36458

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PAUL B. GUNBY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>17</b> YEAR <b>1995</b>                                                                                                                            |  | 3. TIME OF DEATH<br><b>9:25 AM</b>                                                                  |                                                                                                                                                        |
| 4. SOCIAL SECURITY NUMBER<br><b>212-03-8872</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 7, 1906</b>                                         |                                                                                                                                                        |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>GLEN BURNIE</b>                                                                                                                                           |  | 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>                                                          |                                                                                                                                                        |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>Anne Arundel</b>                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Severna Park</b>                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                                        |
| 10e. STREET AND NUMBER<br><b>33 Holly Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 10f. ZIP CODE<br><b>21146</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                         |                                                                                                                                                        |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |                                                                                                                                                        |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Owner</b>                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>General Merchandise Store</b>                                  |                                                                                                                                                        |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Paul L. Gunby</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jessie A. Wilkins</b>                                                                                                                       |  |                                                                                                     |                                                                                                                                                        |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Paul B. Gunby, Jr. (son)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>216 Old County Road - Severna Park, MD 21146</b>                                                |  |                                                                                                     |                                                                                                                                                        |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Paul's Episcopal Cemetery 11/21/95</b>                 |  | 20c. LOCATION — City or Town, State<br><b>Marion Station, MD</b>                                                                                                                                    |  |                                                                                                     |                                                                                                                                                        |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert H. Bradshaw</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bradshaw &amp; Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817</b>                                                                                   |  |                                                                                                     |                                                                                                                                                        |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. multi system failure secondary to:</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Ruptured Abdominal Aortic Aneurysm</b><br><b>c. MYOCARDIAL INFARCTION</b><br><br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate interval Between Onset and Death<br><b>5 days</b><br><b>5 days</b>                                                                         |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                           |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                                        |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                   |  |                                                                                                     |                                                                                                                                                        |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Medical House Officer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>D43977</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 17th '95</b>                                          |                                                                                                                                                        |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Amokm OKETUNSI, 301 HOBBY DRIVE, GLEN BURNIE, MD 21061</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                                                                                                                                           |  |                                                                                                     |                                                                                                                                                        |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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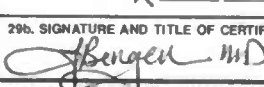

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE CARLYLE GRAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>14</b> YEAR <b>1995</b>                                                                                                                        |  | 3. TIME OF DEATH<br><b>2:38 A</b>                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-30-1236</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Nov. 27, 1933</b>                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Prince George's General Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cheverly</b>                                                                                                                                          |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b>                                               |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>Prince George's</b>                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Upper Marlboro</b>                                        |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 10e. STREET AND NUMBER<br><b>#2 Isham Court</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><b>20772</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                              |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Biologist Lab Technician</b>                                                                                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Food and Drug Administration</b>                                                                                                                           |  |                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George C. Gray</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie L. Butler</b>                                                                                                                     |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Romaine T. Gray</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>#2 Isham Ct., Upper Marlboro, MD 20772</b>                                                  |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery Nov. 17, 1995</b>                                                                                                                                                               |  | 20c. LOCATION — City or Town, State<br><b>Clinton, MD</b>                                                                                                                                       |  |                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lee Funeral Home, Inc.<br/>6633 Old Alexander Ferry Rd.<br/>Clinton, MD 20735</b>                                                                        |  |                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. ATHEROSCLEROSIS of great vessels</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. HYPERTENSION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate interval Between Onset and Death<br><b>seconds</b><br><b>years</b><br><b>years</b> |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D25925</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 15, 1995</b>                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. BERGER MD #205, 7720 WISCONSIN AVE, Bethesda, Md 20814</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 22 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |  |
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| 1. DECEDENT'S NAME (First, Middle, Last)<br>Forrest Eugene Gray Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 19, 1995                                                                                                                                             |  | 3. TIME OF DEATH<br>1:36 P M                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br>578-09-0506                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br>86 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Oct. 13, 1909                              |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Washington DC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                 |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Physicians Memorial Hospital                                                                                                      |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>La Plata                                      |  |
| 9c. COUNTY OF DEATH<br>Charles                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                 |  | 10a. STATE<br>Maryland                                                                                                                                                                              |  |                                                                                      |  |
| 10b. COUNTY<br>Charles                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br>Waldorf                                                                                                                                                              |  |                                                                                      |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                 |  | 10e. STREET AND NUMBER<br>1007 Stone Avenue                                                                                                                                                         |  |                                                                                      |  |
| 10f. ZIP CODE<br>20602                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                |  |                                                                                      |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Mechanic                                                                                                                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Meat Packing Company                                                                                                                                              |  |                                                                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Franklin G. Gray                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Margaret E. Giesler                                                                                                                            |  |                                                                                      |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Marion E. Gray                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1007 Stone Avenue, Waldorf, MD 20602                                                               |  |                                                                                      |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery 11-22                                                                                                                                                                                    |  | 20c. LOCATION — City or Town, State<br>Suitland, Maryland                                                                                                                                           |  |                                                                                      |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Mark G. Brohawn</i><br>Mark G. Brohawn M00053                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br>Huntt Funeral Home<br>P. O. Box 156, Waldorf, MD 20604-0156                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>(R) Hemispheric Haemorrhagic Infarct</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                       |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                 |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                      |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Sujata Poisson</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                 |  | 29c. LICENSE NUMBER<br>D-47337                                                                                                                                                                      |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/20/95                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Sujata Poisson 11350 Pembroke Square Suite 312 Waldorf, Maryland 20603                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 22 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                 |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Shuckor-Randall</i>                                                                                                                                           |  |                                                                                      |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36461

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>NELLIE F. GIDDINGS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>17</b> YEAR <b>95</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>10:20 A M</b>                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220 012880</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4 16 22</b>                                       |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>411 Cedar Street Apt. 1</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cambridge</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>Dorchester</b>                                                    |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Dorchester</b>                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Cambridge</b>                                             |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>411 Cedar Street Apt. 1</b>                                                                                                                                        |  |                                                                                             |  |
| 10f. ZIP CODE<br><b>21613</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                     |  |                                                                                             |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>linesman</b>                                                                                                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Produce Factory</b>                                                                                                                                        |  |                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Samuel Banks Travers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Julie Edna Ross</b>                                                                                                                     |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Robinson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>500 Pine Street Cambridge, Maryland 21613</b>                                               |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                                                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State<br><b>Cambridge, Maryland</b>                                                                                                                               |  | 20d. DATE                                                                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Janelle C. Henry</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Henry Funeral Home<br/>510 Washington St. Cambridge, Maryland</b>                                                                                        |  |                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>CORONARY HEART DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>MINUTES</b><br><b>425</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD</b><br><b>HBP</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                        |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                 |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                             |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Hubert L. Flory MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D22773</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/95</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HUBERT L. FLORY MD 503 BYPW ST OAMBAKE MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. Randolph</b>                                                                                                                                            |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36462

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MADELINE Gertrude GREEN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>14</b> YEAR <b>1995</b>                                                                                                                            |  | 3. TIME OF DEATH<br><b>7:30 A</b> M                                                               |  |
| 4. SOCIAL SECURITY NUMBER<br><b>055-10-1233</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>90</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/10/05</b>                                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>NY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Berlin Nursing Home</b>                                                                                                                                                                                                               |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Berlin</b>                                                                                                                                                |  | 9c. COUNTY OF DEATH<br><b>Worcester</b>                                                           |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br><b>Worcester</b>                                                                                                                                                                                                                                                                            |  | 10c. CITY, TOWN OR LOCATION<br><b>Ocean City</b>                                                                                                                                                    |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>106 7th St.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21842</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                       |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                           |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>College (1-4 or 5 +)</b>                                                                                                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                      |  |                                                                                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Francis Lowe</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Augusta Stoekler</b>                                                                                                                        |  |                                                                                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Adele DiDio</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>106 7th St. Apt. 2 Ocean City, MD 21842</b>                                                     |  |                                                                                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cape Henlopen Crematory 11/14/95 Frankford, DE</b>                                                                                                                                                                   |  | DATE                                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State                                                               |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Burbage Funeral Home<br/>108 Williams St. Berlin, MD 21811</b>                                                                                               |  |                                                                                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b><br>Approximate Interval Between Onset and Death <b>4 DAYS</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>DEMENTIA</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>HYPERTENSION</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |                                                                                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO              |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                   |  |
| 29a. CERTIFIER (Check one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D46257</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/14/95</b>                                            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>EDWIN CASTANEDA, MD 314 FRANKLIN AVE. SUITE 103 BERLIN MD 21811</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 15 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                     |  |                                                                                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36463

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Helen Harriett HEBB</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 19 1995</b>                                                                                                                                     |  | 3. TIME OF DEATH<br><b>0605 A.M.</b>                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-05-6651</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.                                                                                                                                                  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 25, 1908</b>                                         |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>                                                                                                                                          |  | 9c. COUNTY OF DEATH<br><b>Washington</b>                                                            |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                     |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br><b>Washington</b>                                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>730 Maryland Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21740</b>                                                                                                                                                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                         |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>homemaker</b>                                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>her own</b>                                                                                                                                                  |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Elmer George Spickler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bertha Creager</b>                                                                                                                        |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert E. Miller</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>241 Nottingham Rd., Hagerstown, Maryland 21740</b>                                            |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery 11-21-95</b>                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>                                                                                                                                |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott M. Minnich</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME<br/>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>                                                                                                                                                                                             |  |                                                                                                                                                                                                   |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Coronary &amp; vascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Coronary &amp; vascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                             |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                      |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. J. DeLeon</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D2E523</b>                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/20/95</b>                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. J. DeLeon MD 1110 E. CAMP ROAD HAGERSTOWN MD 21740</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 20 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John J. DeLeon</i>                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36464

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Robert Lee HIGGINS, Sr.                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 13, 1995                                                                                                                                             |  | 3. TIME OF DEATH<br>2315 M                                                                                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br>216-22-9744                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br>68 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Jan. 17, 1927                                                                                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown                                                                                                                                                   |  | 9c. COUNTY OF DEATH<br>WASHINGTON                                                                                                                      |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br>Washington                                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br>Williamsport                                                                                                                                                         |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br>14905 Clear Spring Rd.                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  | 10f. ZIP CODE<br>21795                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                                                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8                                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Lead Man                                                                                                                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Leather Tanning                                                                                                                                                   |  |                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>David Martin Higgins                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Susan Anna Henson                                                                                                                              |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Susan R. Higgins                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>14905 Clear Spring Rd. Williamsport, MD 21795                                                      |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenlawn memorial Park Nov. 17, 1995                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State<br>Williamsport, MD 21795                                                                                                                                       |  |                                                                                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Craig H. Osborn</i>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  | 22. NAME AND ADDRESS OF FACILITY<br>OSBORNE FUNERAL HOME<br>Williamsport, MD 21795                                                                                                                  |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  | a. <i>Coronary artery disease &amp; previous MI</i> 15 yrs                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | b. <i>SP CABG</i> 15 yrs                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  | c. <i>Congestive heart failure</i> 2 mos                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | d. <i>ASCVD</i> 15 yrs                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ED/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                   |  |                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> M.D.                                                                                                                                                                                                                                        |  | 29c. LICENSE NUMBER<br>DH1137                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/14/95                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>HARRY L. CORPUS</i> Washington County Hosp<br>Hagerstown, MD                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 16 1995                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                     |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36465

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                        |                                                                         |                                                                                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Miriam May Hoff</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>20</b> YEAR <b>1995</b>                                                                                                                                                                                                                                |  |                                                                                        |                                                                         | 3. TIME OF DEATH<br><b>0110</b> M                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-80-8164</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.                                                                                                                                                                                                                                                        |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 02, 1913</b>                            |                                                                         | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Carroll County Gen. Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>                                                                                                                                                                                                                                               |  |                                                                                        |                                                                         | 9c. COUNTY OF DEATH<br><b>Carroll</b>                                                                                                       |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br><b>Carroll</b>                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>Westminster</b>                                                                                                                                                                                                                                                       |  |                                                                                        |                                                                         | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><b>14 Kemper Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 10f. ZIP CODE<br><b>21157</b>                                                                                                                                                                                                                                                                           |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                  |                                                                         |                                                                                                                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                     |  |                                                                                        | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                                                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>                                      |                                                                         |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Clinton Weaver Kroh</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Estella May Bachman</b>                                                                                                                                                                                                                         |  |                                                                                        |                                                                         |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Shirley A. Hoff</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14 Kemper Avenue, Westminster, MD 21157</b>                                                                                                                                                         |  |                                                                                        |                                                                         |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Pipe Creek Cemetery 11/24/95</b>                                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State<br><b>Uniontown, MD</b>                            |                                                                         |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Katherine Potts-Switzer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Potts Funeral Home &amp; Chapel<br/>412 Washington Rd., Westminster, MD 21157</b>                                                                                                                                                                                |  |                                                                                        |                                                                         |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                        |                                                                         | Approximate Interval Between Onset and Death<br><b>1 DAY</b>                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>lymphoma</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                        |                                                                         | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                        |                                                                         | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                        |                                                                         |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br><b>M</b>                                                        |                                                                         | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                       |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) |                                                                         |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |  |                                                                                        |                                                                         |                                                                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                     |  |                                                                                                                                                  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M. Nasir MD</b>                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>D35711</b>                                                   |                                                                         | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/21/95</b>                                                                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>M. NASIR MD 295 STONER RD WESTMINSTER MD 21157</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                        |                                                                         |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 22 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Swisher Randall</b>                                                                                                                                                                                                                                                |  |                                                                                        |                                                                         |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.








95 36466

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                     |                                                              |                                                                                                                                             |                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FLORENCE CHAPMAN HIMES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                           |                                                  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>19</b> YEAR <b>1995</b>                                                                                                                                 |                                                              | 3. TIME OF DEATH<br><b>06:25</b> M                                                                                                          |                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>164-12-8957</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                            | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS. |                                                                                                                                                                                                     | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JUL 01 1917</b> |                                                                                                                                             | 8. BIRTHPLACE (State or Foreign Country)<br><b>Illinois</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>89 MEDICAL GROUP (Malcolm Grow Hosp.)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                           |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ANDREWS AFB, MD</b>                                                                                                                                       |                                                              | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGES</b>                                                                                                |                                                             |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>PRINCE GEORGES</b>                                                                                                                                                                                                                                                      |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>UPPER MARLBORO</b>                                                                                                                                                |                                                              | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                         |                                                             |  |
| 10e. STREET AND NUMBER<br><b>7702 LOCRISS DRIVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                           |                                                  | 10f. ZIP CODE<br><b>20772</b>                                                                                                                                                                       |                                                              | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                |                                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                          |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                                              | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                     |                                                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Administrative Assistant</b>                                                                                                                                          |                                                  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>U. S. Government</b>                                                                                                                                           |                                                              |                                                                                                                                             |                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Fletcher Chapman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                           |                                                  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Edith Brodick</b>                                                                                                                      |                                                              |                                                                                                                                             |                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nancy and Paul Vogel</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                           |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4511 Venable Ave, Alexandria, Virginia 22304</b>                                                |                                                              |                                                                                                                                             |                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Nov 25, 1995</b><br><b>Arlington National Cemetery</b>                                                                                                                                              |                                                  | 20c. LOCATION — City or Town, State<br><b>Fort Myer, Virginia</b>                                                                                                                                   |                                                              |                                                                                                                                             |                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                           |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lee Funeral Home, Inc 6633</b><br><b>Old Alexandria Ferry Road, Clinton, Md 20735</b>                                                                        |                                                              |                                                                                                                                             |                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PSEUDONIONAS SEPSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>PANCYTOPENIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>NON-HODGKINS LYMPHONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>DAYS</b><br><b>DAYS</b><br><b>MONTHS</b> |  |                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                     |                                                              |                                                                                                                                             |                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                     |                                                              | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                     |                                                              | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                             |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |                                                  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                              |                                                              | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                       |                                                             |  |
| 28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                         |                                                  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |                                                              |                                                                                                                                             |                                                             |  |
| 29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                     |                                                              |                                                                                                                                             |                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                           |                                                  | 29c. LICENSE NUMBER<br><b>MI 4301406999</b>                                                                                                                                                         |                                                              | 29d. DATE SIGNED (Month, Day, Year)<br><b>19 NOV 1995</b>                                                                                   |                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JAMES W. ORTMEYER, MAJ, USAF, MC</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                           |                                                  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>89 MDG/MDOS 1050 W PERIMETER RD SUITE C1-7</b><br><b>ANDREWS AFB, MD 20331-6600</b>                       |                                                              |                                                                                                                                             |                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 22 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                          |                                                  |                                                                                                                                                                                                     |                                                              |                                                                                                                                             |                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36467

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Robert Neal Houchin Sr.                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 20, 1995                                                                                                                                             |  | 3. TIME OF DEATH<br>2:05 P M                                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br>228-12-2035                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>73 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>June 29, 1922                                                |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br>6551 Matthews Road                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Bryans Road                                                                                                                                                  |  | 9c. COUNTY OF DEATH<br>Charles                                                                      |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br>Charles                                                                                                                                                                                                                                                                                     |  | 10c. CITY, TOWN OR LOCATION<br>Bryans Road                                                                                                                                                          |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>6551 Mathews Road                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>20616                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II                                                                                                                                                  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) College (1-4 or 5+)                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Steamfitter                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Federal Government                                                                                                                                                |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Neal Houchin                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lura Stone                                                                                                                                     |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Frances V. Houchin                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6551 Matthews Rd., Bryans Road, Md. 20615                                                          |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maryland Veterans' Cem. 11-24                                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br>Cheltenham, MD                                                                                                                                               |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Mark G. Brohawn</i><br>Mark G. Brohawn M00053                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>Huntt Funeral Home<br>P. O. Box 156, Waldorf, MD 20604-0156                                                                                                     |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  | a. <u>CANCER OF PROSTATE</u><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  | Approximate Interval Between Onset and Death<br>4M                                                  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                          |  | b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                     |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Krishan Mathur</i>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>D-28352                                                                                                                                                                      |  | 29d. DATE SIGNED (Month, Day, Year)<br>11-21-95                                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Krishan Mathur, MD P.O. Box 2729 La Plata, Md. 20646                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 22 1995                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Randall</i>                                                                                                                                             |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




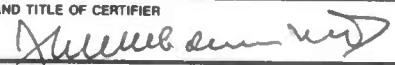

AMENDED 17-11-21-95 aft

95 36468

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Imogene Harper Hollywood                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 20 1995                                                                                                                                            |  | 3. TIME OF DEATH<br>3:30A M                                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br>233-32-9435                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>73 YRS.                                                                                                                                                         |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Dec 21 1921                                                |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>189 Duke Of Gloucester Street                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Annapolis                                                                                                                                                  |  | 9c. COUNTY OF DEATH<br>Anne Arundel                                                               |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                   |  |
| 10a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10b. COUNTY<br>Anne Arundel                                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br>Annapolis                                                                                                                                                          |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>189 Duke of Gloucester Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21401                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                                    |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                         |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 2 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                                                                                                                                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home                                                                                                                                                            |  |                                                                                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Festus Allen Harper                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Stella Fogarty                                                                                                                               |  |                                                                                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Michael A. Hollywood                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>189 Duke of Gloucester St. Annapolis, MD 21401                                                   |  |                                                                                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. Mary's Cemetery 11/22/95                                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br>Annapolis, Maryland                                                                                                                                        |  |                                                                                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>John M. Taylor Funeral Home<br>147 Duke of Gloucester St. Annapolis, MD                                                                                       |  |                                                                                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia, lobar</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Cause of the lung</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Approximate Interval Between Onset and Death<br>10d.<br>2 yrs. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____<br>_____                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                       |  |                                                                                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |  |                                                                                                   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                          |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                      |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>D05259                                                                                                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 20, 1995                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>John L. Pedeman, M.D. 1407 Forest Drive Annapolis, Maryland 21403                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                   |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 21 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                  |  |                                                                                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36469

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EMILY LEE HEUSI</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 17 1995</b>                                                                                                                                                                                                                                                        |  | 3. TIME OF DEATH<br><b>2:35 p.m.</b>                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-05-2546</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.                                                                                                                                                                                                                                                                 |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9/30/1916</b>                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian Multi-Medical Nursing</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                             |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                     |  |
| 10a. STATE<br><b>Penna.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>York</b>                                                                                                                       |  | 10c. CITY, TOWN OR LOCATION<br><b>Delta</b>                                                                                                                                                                                                                                                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>277 Clubhouse Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 10f. ZIP CODE<br><b>17314</b>                                                                                                                                                                                                                                                                                    |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                               |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Manager</b>                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Beauty Salon</b>                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Stewart Monroe Wood</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alberta Schaffer</b>                                                                                                                                                                                                                                     |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Frederick H. Heusi</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>277 Clubhouse Road Delta, PA 17314</b>                                                                                                                                                                       |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____                                                                                                                                                                                                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park 11/20</b>                           |  | 20c. LOCATION — City or Town, State<br><b>Parkville, MD</b>                                                                                                                                                                                                                                                      |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jeffrey P. Lovelidge</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Harkins Funeral Home, Inc. Delta, PA</b>                                                                                                                                                                                                                                  |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ASPIRATION PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. Chronic obstructive Pulmonary Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>10 YEARS</b> |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Left hemiparesis secondary to Right cerebrovascular accident</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                           |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                           |  |                                                                                                     |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                       |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Howard B. Chen MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>D21680</b>                                                                                                                                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/95</b>                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HOWARD B. CHEN, M.D. 6717 PARK HEIGHTS AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                  |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Harrell</i>                                                                                                                                                                                                                                                        |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36470

AMENDED #6, 11/20/95, B.P., WORCESTER CO.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ERMA E. HEARNE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>7</b> YEAR <b>1995</b>                                                                                                                         |  | 3. TIME OF DEATH<br><b>11:40 P M</b>                                                            |                                                                                                                                          |
| 4. SOCIAL SECURITY NUMBER<br><b>169-01-0884</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>(86) 85</b> YRS.                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>2-4-09</b>                                         |                                                                                                                                          |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BERLIN NURSING &amp; REHAB. CTR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BERLIN</b>                                                                                                                                            |  | 9c. COUNTY OF DEATH<br><b>WORCESTER</b>                                                         |                                                                                                                                          |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                          |
| 10a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10b. COUNTY<br><b>WORCESTER</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>BERLIN</b>                                                                                                                                                    |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                          |
| 10e. STREET AND NUMBER<br><b>9700 HEALTHWAY DRIVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21811</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                                                          |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                         |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |                                                                                                                                          |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>                                                                                                                                               |  |                                                                                                 |                                                                                                                                          |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN EDWIN SOX</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ORFA SOX</b>                                                                                                                            |  |                                                                                                 |                                                                                                                                          |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JAMES BENDEL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12 PARK COURT, POTTSTOWN, PA., 19454</b>                                                    |  |                                                                                                 |                                                                                                                                          |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SALISBURY CREMATORY</b>                                                                                                                                                                                  |  | DATE<br><b>11-10</b>                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br><b>SALISBURY, MD.</b>                                    |                                                                                                                                          |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John G. Ullrich</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ULLRICH FUNERAL HOME BERLIN, MD.</b>                                                                                                                     |  |                                                                                                 |                                                                                                                                          |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Congestive Heart Failure</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Coronary Artery Disease</b><br>c. <b>Age</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>1 month</b>                                                                           |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Schizophrenia controlled</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                    |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                          |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |                                                                                                                                          |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                          |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Federico G. Arthes</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D02026</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 8-95</b>                                          |                                                                                                                                          |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FEDERICO G. ARTHE 1622A OCEAN PINES BERLIN MD 21811</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                          |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 20 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John Sanderford</i>                                                                                                                                             |  |                                                                                                 |                                                                                                                                          |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36471

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CORNELIA ANN INGRAM</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>19</b> YEAR <b>1995</b>                                                                                                                        |  |                                                                                             |  | 3. TIME OF DEATH<br><b>12:55 P M</b>                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-42-7258</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br><b>50</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>SEPT 27, 1945</b>                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>WASHINGTON COUNTY HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>HAGERSTOWN</b>                                                                                                                                        |  |                                                                                             |  | 9c. COUNTY OF DEATH<br><b>WASHINGTON</b>                                                                                                |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br><b>WASHINGTON</b>                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>BOONSBORO</b>                                                                                                                                                 |  |                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><b>141 SOUTH MAIN STREET</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  | 10f. ZIP CODE<br><b>21713</b>                                                                                                                                                                   |  |                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |                                                                                             |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                                                              |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>                                                                                                                                                      |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>                                                                                                                                                |  |                                                                                             |  |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GRANVIL E. INGRAM</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>V. VIRGINIA ECTON</b>                                                                                                                   |  |                                                                                             |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>GRANVIL E. INGRAM</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2244 DARGAN ROAD, SHARPSBURG, MARYLAND 21782</b>                                            |  |                                                                                             |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SAMPLES MANOR CEMETERY 11/22/95</b>                                                                                                                                                           |  |                                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br><b>SAMPLES MANOR, MD.</b>                            |  |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Paul M. Dean</i> Paul M. Dean                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BAST FUNERAL HOME 7606 Old National Pike Boonsboro, MD 21713</b>                                                                                         |  |                                                                                             |  |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>upper Gastro intestinal bleeding</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Nas Hodgkin's Lymphoma</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             |  | Approximate Interval Between Onset and Death<br><i>1 day</i><br><i>over 1 year</i>                                                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Seizure Disorder Cerebrovascular Accident</i><br><i>with left Hemiparesis</i>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                       |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |  |                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>State MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br><b>D18019</b>                                                                                                                                                            |  |                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 20 1995</b>                                                                               |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>VASANT DATTA MD 330 MILL ST HAGERSTOWN MD 21740</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 2 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br><i>Sally...</i>                                                                                                                                                    |  |                                                                                             |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36472

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Harry D. IDEN</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH <u>NOV</u> DAY <u>24</u> YEAR <u>1995</u>                                                                                                                                 |  | 3. TIME OF DEATH<br><u>8:29 P M</u>                                                                 |                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br><u>220-18-1072</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                            |  | 6. AGE (In yrs. last birthday)<br><u>71</u> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>March 5, 1924</u>                                         |                                                                                                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Western Maryland Hospital Center</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Hagerstown</u>                                                                                                                                            |  | 9c. COUNTY OF DEATH<br><u>Washington</u>                                                            |                                                                                                                                             |
| 10a. STATE<br><u>MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><u>Washington</u>                                                                                                                                                                                                                                                          |  | 10c. CITY, TOWN OR LOCATION<br><u>Hancock</u>                                                                                                                                                       |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                             |
| 10e. STREET AND NUMBER<br><u>117 Fairview Drive</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                           |  | 10f. ZIP CODE<br><u>21750</u>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                         |                                                                                                                                             |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                          |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>White</u>                             |                                                                                                                                             |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>6</u><br>College (1-4 or 5+) <u></u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Labor</u>                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Contractor</u>                                                                                                                                                 |  |                                                                                                     |                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Ernest Melvin Iden</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Ethel Lillian Stotler</u>                                                                                                                   |  |                                                                                                     |                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Grace A. Iden</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>117 Fairview Drive Hancock, MD 21750</u>                                                        |  |                                                                                                     |                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Stone Bridge Cemetery 11/27/95 Hancock, MD 21750</u>                                                                                                                                                |  | 20c. LOCATION — City or Town, State<br><u>21750</u>                                                                                                                                                 |  |                                                                                                     |                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                           |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Grove Funeral Home<br/>P.O. Box 368 Hancock, MD 21750</u>                                                                                                    |  |                                                                                                     |                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. PNEUMONIA OF UNKNOWN ETIOLOGY</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><u>b. CEREBRAL VASCULAR ACCIDENT</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u></u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <u></u><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death<br><u>2 WEEKS</u><br><u>OCTOBER 1995</u>                                                       |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>CHRONIC RENAL INSUFFICIENCY, MALNUTRITION,</u><br><u>DECUBITUS ULCER</u><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                           |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                              |  | 28b. TIME OF INJURY<br><u>M</u>                                                                     |                                                                                                                                             |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                         |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Mark Jameson, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                           |  | 29c. LICENSE NUMBER<br><u>031537</u>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>Nov 24, 1995</u>                                          |                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>MARK JAMESON, WESTERN MARYLAND CENTER,<br/>1500 PENNSYLVANIA AVE., HAGERSTOWN, MD 21742</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br><u>NOV 30 1995</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                           |  | 32. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36473

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARY IRELAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV. 14 1995                                                                                                                                                                                                                                                         |  | 3. TIME OF DEATH<br>7:15pm M                                                                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br>219-26-5075                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>68 YRS.                                                                                                                                                                                                                                                                  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>AUG. 10 1927                                                                                                                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>GEORGIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br>1213 SLATER ROAD                                                                                                                                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE                                                                                                                                       |  |
| 9c. COUNTY OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 10a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                     |  | 10b. COUNTY<br>BALTIMORE                                                                                                                                                               |  |
| 10c. CITY, TOWN OR LOCATION<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                   |  | 10e. STREET AND NUMBER<br>1213 SLATER ROAD                                                                                                                                             |  |
| 10f. ZIP CODE<br>21225                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                       |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                          |  | 14. RACE - American Indian, Black, White, etc.<br>Specify:<br>BLACK                                                                                                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7th College (14 or 5+) 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>COOK                                                                                                                                                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br>HOWARD JOHNSON                                                                                                                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>PAUL GRIMES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>FANNIE RICHARDSON                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>HENRY IRELAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1213 SLATER ROAD BALTIMORE, MD. 21225                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MT. CALVARY CHURCH CEME. 11/20/95                                                                                                                                                                                       |  | 20c. LOCATION - City or Town, State<br>ARNOLD, MD.                                                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Harry M. Reese                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br>REESE & SONS MORTUARY, P.A.<br>821 WEST ST. ANNAPOLIS, MD. 21401                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic non-small lung cancer to brain and spine<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                           |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                        |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Aron W Berkman MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 29c. LICENSE NUMBER<br>022782                                                                                                                                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br>Nov. 17, 1995                                                                                                                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Aron W Berkman MD Harbor Hospital Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 24 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>J. D. [Signature]                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68766

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36474

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                 |  |                                                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Alex K. ILLES</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 18 95</b>                                                                                                                                     |  | 3. TIME OF DEATH<br><b>0729</b> M                                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>070-14-2980</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>08/11/22</b>                                                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>University Hospital</b>                                                                                                    |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                           |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                   |  |                                                                                                                   |  |
| 10b. COUNTY<br><b>Caroline</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10c. CITY, TOWN OR LOCATION<br><b>Federalsburg</b>                                                                                                                                              |  |                                                                                                                   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10e. STREET AND NUMBER<br><b>5244 Clarks Canning House Road</b>                                                                                                                                 |  |                                                                                                                   |  |
| 10f. ZIP CODE<br><b>21632</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                           |  |                                                                                                                   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                           |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Tenth</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Carpenter</b>                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction/ Naval Shipyard</b>                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Kalman Illes</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sophia Farkas Illes Bratto</b>                                                                                                          |  |                                                                                                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Janet Mohr</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>63 Pine Tree Dr., Columbia, PA 17512</b>                                                    |  |                                                                                                                   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Eastern Shore Veterans 21</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20c. LOCATION — City or Town, State<br><b>Hurlock, Maryland</b>                                                                                                                                 |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Michael F. Eskow</b>                                              |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Frampton-Hawkins-Eskow Funeral Home<br/>PO Bx 43, Federalsburg, MD 21632</b>                                                                                                                                                                                                                                                                                                              |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Aortic Aneurysm Pseudoaneurysm Rupture</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                 |  |                                                                                                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO             |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                 |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                                                   |  |
| 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                     |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                 |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                                   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                 |  |                                                                                                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Matthew C. Cullen MD</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 29c. LICENSE NUMBER<br><b>07246</b>                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/18/95</b>                                                            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JONATHAN CALUPE, MD UNIVERSITY OF MD MEDICAL SYSTEM, Balt. Md</b>                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                 |  |                                                                                                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                                                                                                                                       |  |                                                                                                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68766 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

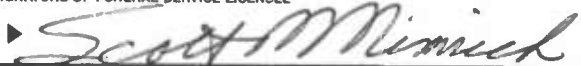


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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Gertrude Sada Jones</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 15 1995</b>                                                                                                                                       |  |                                                                                      |  | 3. TIME OF DEATH<br><b>12:37 A.M.</b>                                                                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-09-4733</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 25 1914</b>                           |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>                                                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Reeders Memorial Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Boonsboro</b>                                                                                                                                             |  |                                                                                      |  | 9c. COUNTY OF DEATH<br><b>Washington</b>                                                                                                    |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>Washington</b>                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>                                     |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><b>442 Jefferson Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21740</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |                                                                                                                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>           |  |                                                                                                                                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Laundry</b>                                                                                                                                                    |  |                                                                                      |  |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George N. Messner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Ellen Cave</b>                                                                                                                         |  |                                                                                      |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Holder</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>442 Jefferson Street Hagerstown, Md. 21740</b>                                                  |  |                                                                                      |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Boonsboro Cemetery 11-17-95</b>                                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br><b>Boonsboro, Maryland</b>                                                                                                                                   |  |                                                                                      |  |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Minnich Funeral Home<br/>415 E. Wilson Blvd. Hagerstown, Md. 21740</b>                                                                                       |  |                                                                                      |  |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | Approximate interval Between Onset and Death<br><b>3-4 days</b><br><b>3-4 days</b>                                                          |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diagnosis: Myocardial Infarction, Arteriosclerosis, Coronary Artery Disease, Chronic Carotid Artery Atherosclerosis</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                           |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                       |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Dr. Vasant Datta</b>                                                                                                                                                    |  | 29c. LICENSE NUMBER<br><b>D 18019</b>                                                                                                                                                               |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 15, 1995</b>                           |  |                                                                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Vasant Datta 334 Mill Street Hagerstown, MD. 21740 301-739-7100</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 16 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                    |  |                                                                                      |  |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36476

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DOROTHY DAY JOHNSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>14</b> YEAR <b>1995</b>                                                                                                                                                                                                                       |  | 3. TIME OF DEATH<br><b>1535 P.</b>                                                                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>229 34 9400</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.                                                                                                   |  |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>8/22/03</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>W. Virginia</b>                                                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>                                                                                                                                                                                                                                       |  | 9c. COUNTY OF DEATH<br><b>Washington</b>                                                                                                           |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. COUNTY<br><b>Washington</b>                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>                                                                                                   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10e. STREET AND NUMBER<br><b>750 Dual Hwy.</b>                                                                                                                                                                                                                                                 |  | 10f. ZIP CODE<br><b>21740</b>                                                                                                                      |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES       |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                     |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                                                                                                                                                                                                                     |  |                                                                                                                                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>8</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Domestic</b>                                                                                                  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John B. Day</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Virgie Mason Day</b>                                                                                                                                                                                                                   |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nettie A. Hughes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>43 W. Bethel St. Hagerstown, MD 21740</b>                                                                                                                                                  |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                           |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rose Hill 11/18/95</b>                                                                                                                                                                                   |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, MD.</b>                                                                                      |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Thomas E. Watts</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Watsons Funeral Home</b><br><b>24 W Bethel St. Hagerstown, MD 21740</b>                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Acute myocardial infarction</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br><b>Arteriosclerotic heart disease</b><br><br><b>Left ventricular aneurysm</b> |  | Approximate Interval Between Onset and Death<br><b>2 days</b><br><b>many years</b>                                                                                                                                                                                                             |  |                                                                                                                                                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Left ventricular aneurysm</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                          |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                    |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                    |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                             |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                    |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edward J. [Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 29c. LICENSE NUMBER<br><b>008557</b>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)                                                                                                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 16 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                |  |                                                                                                                                                    |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36477

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>VROOMA M. JOHNSON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH NOV. DAY 15 YEAR 1995                                                                                                                                                     |  | 3. TIME OF DEATH<br>12 00 P M                                                        |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br>220-10-6441                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                               |  | 6. AGE (In yrs. last birthday)<br>74 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>SEPT 05, 1995                                 |                                                                  | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND                                                                                |  |                                                                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>449 HIGH STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>CAMBRIDGE                                                                                                                                                    |  |                                                                                      | 9c. COUNTY OF DEATH<br>DORCHESTER                                |                                                                                                                                     |  |                                                                                                                                             |  |
| 10a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br>DORCHESTER                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br>CAMBRIDGE                                             |                                                                  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                 |  |                                                                                                                                             |  |
| 10e. STREET AND NUMBER<br>449 HIGH STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                              |  | 10f. ZIP CODE<br>21613                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                 |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |                                                                                      | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK |                                                                                                                                     |  |                                                                                                                                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) NONE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>CAN LABELER                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br>NATIONAL CAN COMPANY                               |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>WILLIAM JEWS JR.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>NELLIE BROMWELL                                                                                                                                |  |                                                                                      |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>GLORIA SYDNOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>813 BAYLY ROAD CAMBRIDGE, MD 21613                                                                 |  |                                                                                      |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>BETHEL AVE CEMETERY 11-20                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br>CAMBRIDGE, MD                                                                                                                                                |  |                                                                                      |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lewis H. Bowdler</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br>BOARDLEY FUNERAL HOME<br>812 HUBBARD STREET CAMBRIDGE, MD 21613                                                                                                 |  |                                                                                      |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Ischemic Heart Disease</i><br>b. <i>Congestive Heart Failure</i><br>c. <i>Chronic Atrial Fibrillation</i><br>d. <i>Hypertensive Cardiovascular Disease</i><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                  | Approximate Interval Between Onset and Death<br>a. <i>&lt; 1 yr</i><br>b. <i>&lt; 1 yr</i><br>c. <i>&lt; 1 yr</i><br>d. <i>1 yr</i> |  |                                                                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                           |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                       |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                   |  |                                                                                                                                             |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                      |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Judge Washington, M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                              |  | 29c. LICENSE NUMBER<br>P31108                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/17/95                                      |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Judy C. W. Ashington 408 Byrne Street Cambridge, MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 17 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                                                                                                                                           |  |                                                                                      |                                                                  |                                                                                                                                     |  |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 36478

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT LEO JONES</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Oct 27, 1995</b>                                                                                                                                                                                                                                      |  | 3. TIME OF DEATH<br><b>7:30 A M</b>                                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-38-0002</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>55</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec 1, 1939</b>                                                                                                                   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>DEVLIN MANOR NURSING HOME</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND</b>                                                                                                                                                                                                                                       |  | 8c. COUNTY OF DEATH<br><b>ALLEGANY</b>                                                                                                                                         |  |
| 9. RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br><b>Allegany</b>                                                                                                                                                 |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>203 W. Industrial Blvd.</b>                                                                                                                       |  |
| 10f. ZIP CODE<br><b>21502</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                    |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1958-1960</b>                                                                                                                                                                                                                                                             |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                                                                                                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                               |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Former Employee</b>                                                                                                                                                        |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Pharmacy</b>                                                                                                                              |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George B. Jones</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nellie Angela (Clay)</b>                                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Shirley Morgan</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14211 Lower Sunnyside Rd; Mt. Savage, MD 21545</b>                                                                                                                                         |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Sunset Memorial Park 10/29</b>                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br><b>Cumberland, MD</b>                                                                                                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>G. Jones</i>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>                                                                                                                                                                                                     |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| a. <i>Coronary artery disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. Anthony Bollino</i>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>D17565</b>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/95</b>                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Anthony Bollino; 955 Frederick Street; Cumberland, MD 21502</b>                                                                                                                                                                                                                                                                |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 14 1995</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Davidson</i>                                                                                                                                                                                                                                           |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



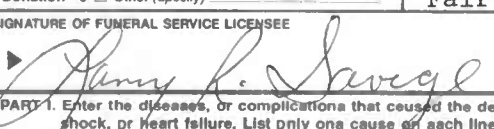
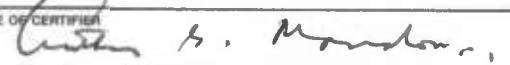
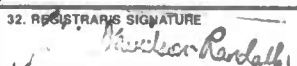
95 36479

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MAURICE ALFRED JACKSON, SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 17, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>12:45 P.M.</b>                                                           |                                                                                                                                         |
| 4. SOCIAL SECURITY NUMBER<br><b>217-10-9977</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 4, 1906</b>                                     |                                                                                                                                         |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Northampton Manor Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>                                                         |                                                                                                                                         |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>Frederick</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                         |
| 10e. STREET AND NUMBER<br><b>309 Broadway</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21702</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                           |                                                                                                                                         |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |                                                                                                                                         |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b><br>College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Construction Worker</b>                                                                                                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Building</b>                                                                                                                                               |  |                                                                                                 |                                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Henry Jackson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Gertrude Howard</b>                                                                                                                |  |                                                                                                 |                                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Michael E. Jackson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>909 Reverdy Road Baltimore, Maryland 21212</b>                                              |  |                                                                                                 |                                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fairview Cemetery</b>                                                                                                                                                                                    |  | DATE<br><b>11/22/95</b>                                                                                                                                                                         |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland</b>                               |                                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Stauffer Funeral Homes, P.A.<br/>1621 Opossumtown Pike Frederick, MD 21702</b>                                                                           |  |                                                                                                 |                                                                                                                                         |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Atherosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>&gt; 5 years.</b>                                                                    |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Subacute Hemiparesis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |                                                                                                                                         |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Dr. Arthur Manalo, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D 18191</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov. 21, 1995</b>                                     |                                                                                                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Arthur Manalo, M.D. 187 Thomas Johnson Drive Frederick, Maryland 21701</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 22 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |

DIVISION OF VITAL RECORDS, P.O. BOX 68766 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36480

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                |                                                                                                                                                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EDNA JENNINGS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV. 12 1995                                                                                                                                                                                                                                                                                                                                                                               |                                | 3. TIME OF DEATH<br>9:45 pm M                                                                                                                                                          |  |
| 4. SOCIAL SECURITY NUMBER<br>212-14-3521                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br>90 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                                                                                                                                                                                                                                                   | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>APRIL 7 1905                                                                                                                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |                                           | 9a. FACILITY NAME (If not institution, give street and number)<br>ANNAPOLIS NURSING & REHAB. CENTER                                                                                                                                                                                                                                                                                                                              |                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br>ANNAPOLIS                                                                                                                                       |  |
| 9c. COUNTY OF DEATH<br>ANNE ARUNDEL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |                                           | 10a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                           |                                | 10b. COUNTY<br>ANNE ARUNDEL                                                                                                                                                            |  |
| 10c. CITY, TOWN OR LOCATION<br>GLEN BURNIE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |                                           | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |                                | 10e. STREET AND NUMBER<br>7866 ROBERTS COURT                                                                                                                                           |  |
| 10f. ZIP CODE<br>21061                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |                                           | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                                                                             |                                | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK                                                                                                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th College (1-4 or 5+) O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |                                           | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>DOMESTIC                                                                                                                                                                                                                                                                                                        |                                | 16b. KIND OF BUSINESS/INDUSTRY<br>SOME ONE ELSE HOME                                                                                                                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JAMES FRANK JENNINGS, SR.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>RACHEL                                                                                                                                                                                                                                                                                                                                                                      |                                |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>SHARON B. CAREY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>741 HYDE PARK GLEN BURNIE, MD. 21061                                                                                                                                                                                                                                                                                            |                                |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |                                           | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>ASBURY TOWN NECK CEME. 11/17/95                                                                                                                                                                                                                                                                                                               |                                | 20c. LOCATION — City or Town, State<br>SEVERNA PARK, MD.                                                                                                                               |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Harry D. Reese                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |                                           | 22. NAME AND ADDRESS OF FACILITY<br>REESE & SONS MORTUARY, P.A.<br>821 WEST ST. ANNAPOLIS, MD. 21401                                                                                                                                                                                                                                                                                                                             |                                |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Renal failure</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br>6 mos. |  |                                                                                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |                                           | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |                                |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |                                           | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                           |                                | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |                                           | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |                                | 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |                                           | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>R. I. Hochman                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |                                           | 29c. LICENSE NUMBER<br>D05192                                                                                                                                                                                                                                                                                                                                                                                                    |                                | 29d. DATE SIGNED (Month, Day, Year)<br>11/15/95                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>R. I. Hochman 16 Murray Ave, Annapolis, Md 21404                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 24 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |                                           | 32. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36481

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LUCY L. JACKSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH <b>11</b> - DAY <b>18</b> - YEAR <b>95</b>                                                                                                                            |  | 3. TIME OF DEATH<br><b>0434 A</b>                                                               |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>219-12-3425</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                       |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>FEB. 13 1924</b>                                      |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ANNE ARUNDEL MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ANNAPOLIS</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>                                                      |                                                                                                       |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>ANNAPOLIS</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>420 CHESAPEAKE AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                  |  | 10f. ZIP CODE<br><b>21403</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                     |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                      |                                                                                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>3yrs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LIBRARY TECHNICIAN</b>                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>NIMITZ LIBRARY</b>                                         |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HOWARD S. LITTLE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CHARLOTTE JOHNSON</b>                                                                                                                   |  |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOHN JACKSON, JR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>420 CHESAPEAKE AVE. ANNAPOLIS, MD. 21403</b>                                                |  |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ANNAPOLIS MEM. GARDENS 11/22/95 ANNAPOLIS, MD.</b>                                                                                                                                         |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  |                                                                                                 |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Larry A. Reese</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>                                                                                |  |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Valvular &amp; Coronary Heart Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>YRS</b><br><b>YRS</b>                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Failure 20 Diabetes Mellitus</b><br><b>Staphylococcus sepsis</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                          |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                       |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John S. Sweeney</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>1218529</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>18 Nov 95</b>                                         |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>600 KIDDERLY AVE. Ste 131, Annapolis, MD 21401</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><b>John D. B. B. B.</b>                                                                                                                                            |  |                                                                                                 |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

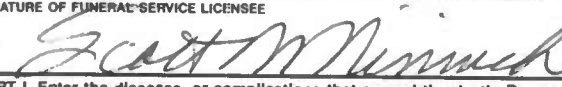
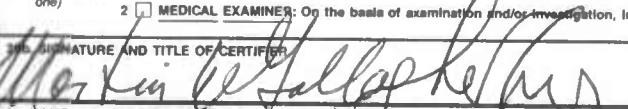





95 36482

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ruth BURPEE KORPI</b>                                                                                                                                                                                                                      |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>15</b> YEAR <b>1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 3. TIME OF DEATH<br><b>2100</b> M                                                                                                                                                      |  |
| 4. SOCIAL SECURITY NUMBER<br><b>021-16-8029</b>                                                                                                                                                                                                                                           |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>93</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 11, 1902</b>                                                                                                                           |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Massachusetts</b>                                                                                                                                                                                                                          |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>                                                                                                                               |  |
| 9c. COUNTY OF DEATH<br><b>Washington</b>                                                                                                                                                                                                                                                  |  |                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. COUNTY<br><b>Washington</b>                                                                                                                                                       |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>                                                                                                                                                                                                                                          |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>11037 Lincoln Avenue</b>                                                                                                                                  |  |
| 10f. ZIP CODE<br><b>21740</b>                                                                                                                                                                                                                                                             |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                          |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                        |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                                                                                                                                                                                                                |  |                                                                                |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                        |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>homemaker</b>                                                                                                                                                            |  |                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>her own</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Gleason</b>                                                                                                                                                                                                                         |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mineola Wyman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ali Korpi</b>                                                                                                                                                                                                                                    |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11037 Lincoln Ave., Hagerstown, Maryland 21740</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                           |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE<br><b>Hagerstown Crematory 11-16-95</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |
| 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>                                                                                                                                                                                                                        |  |                                                                                |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME<br/>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>                                                                                                                                                                            |  |                                                                                |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>Leaking Thoracic aortic aneurysm</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                    |  |                                                                                |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                        |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                    |  |                                                                                |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                     |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                        |  |
| 28b. TIME OF INJURY                                                                                                                                                                                                                                                                       |  |                                                                                |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                    |  |                                                                                |  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                              |  |                                                                                |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                              |  |                                                                                |  | 29c. LICENSE NUMBER<br><b>D31880</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/95</b>                                                                                                                                                                                                                                    |  |                                                                                |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Martin W. Gallagher, JMD Medical Campus Rd., Hagerstown, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 20 1995</b>                                                                                                                                                                                                                                   |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36483

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                  |  |                                                                                                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FERRIS Lee</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>16</b> YEAR <b>1995</b>                                                                                                                                                                                                                       |  |                                                                                  |  | 3. TIME OF DEATH<br><b>1038</b> M                                                                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-54-5925</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>45</b> YRS.                                                                                                                                                                                                                                               |  | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> |  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>                                                                      |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>11-19-1949</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Georgia</b>                                                                                                                                                                                                                                     |  |                                                                                  |  |                                                                                                                                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>                                                                                                                                                                                                                                        |  |                                                                                  |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>                                                                                                                |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                  |  |                                                                                                                                                       |  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br><b>Somerset</b>                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Princess Anne</b>                                                                                                                                                                                                                                            |  |                                                                                  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                       |  |
| 10e. STREET AND NUMBER<br><b>9420 Follow Dutch RD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  | 10f. ZIP CODE<br><b>21853</b>                                                                                                                                                                                                                                                                  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S</b>                                      |  |                                                                                                                                                       |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  |                                                                                  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>                                                                                                                                                                |  |                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Painting</b>                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ellis Pugh</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Florence Kirkland</b>                                                                                                                                                                                                                  |  |                                                                                  |  |                                                                                                                                                       |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Florence Bennett</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9420 Follow Dutch RD. Princess Anne MD. 21853</b>                                                                                                                                          |  |                                                                                  |  |                                                                                                                                                       |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MASADONIA Baptist Cem. 12/21/95 Worcester, MD. 21871</b>                                                                                                                                                 |  |                                                                                  |  | 20c. LOCATION — City or Town, State                                                                                                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Anthony E. Ward</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Anthony E. Ward Funeral Home<br/>30639 Hampden Ave Princess Anne, MD 21853</b>                                                                                                                                                                          |  |                                                                                  |  |                                                                                                                                                       |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Dilated Cardiomyopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Ventricular Arrhythmia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                  |  | Approximate interval Between Onset and Death<br><b>years</b><br><b>days</b>                                                                           |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Failure</b><br><b>Respiratory Distress Syndrome</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO    |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                  |  |                                                                                                                                                       |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/>                                |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                                                  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                          |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jeffrey E. Hetherington</i>                                                                                                                                                                                                                        |  |                                                                                  |  | 29c. LICENSE NUMBER<br><b>D36783</b>                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/95</b>                                                                                                                                                                                                                                         |  |                                                                                  |  | 29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jeffrey E. Hetherington, MD. PRMC SALISBURY, MD. 21801</b> |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Henderson</i>                                                                                                                                                                                                                                    |  |                                                                                  |  |                                                                                                                                                       |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36484

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Preston Lee Kolb</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH <b>Nov.</b> DAY <b>13</b> YEAR <b>1995</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>7:00 A.</b>                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-24-5511</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                      |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Apr. 6, 1926</b>                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                 |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>                                                         |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br><b>Frederick</b>                                                                                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2468 Bear Den Rd.</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                 |  | 10f. ZIP CODE<br><b>21701</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b><br>College (1-4 or 5+) _____                                                                                                                                                                                                                                                                                         |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>farmer</b>                                                                                                                                                                  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>farm owner</b>                                                                                                                                                 |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Kolb</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nettie Ramsburg</b>                                                                                                                         |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Phyllis J. Kolb</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2468 Bear Den Rd., Frederick, Md. 21701</b>                                                     |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Reformed Cemetery</b>                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><b>11/16 Middletown, Md.</b>                                                                                                                                 |  | 20d. DATE<br><b>11/16</b>                                                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald B. Thompson</i>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                 |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Donald B. Thompson Funeral Home<br/>31 E. Main St., Middletown, Md. 21769</b>                                                                                |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  | a. <i>Cerebral vascular accident</i><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  | Approximate Interval Between Onset and Death<br><i>10 years</i>                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  | b. <i>Arteriosclerotic vascular disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  | <i>12 years</i>                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | d. _____<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                          |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                 |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Le Roy T. Davis, M.D.</i>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                 |  | 29c. LICENSE NUMBER<br><b>D01902</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/20/95</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>Dr. Le Roy T. Davis 801 Toll House Ave. Frederick MD 21701</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 20 1995</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                 |  | 32. REGISTRAR'S SIGNATURE<br><i>Davidson Randall</i>                                                                                                                                                |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36485

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Catherine Frances Kingan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |                                           | 2. DATE OF DEATH<br>MONTH Nov DAY 14 YEAR 1995<br>11-14-95                                                                                                                                          |  | 3. TIME OF DEATH<br>0941                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br>224-32-1572                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             | 6. AGE (In yrs. last birthday)<br>67 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 30, 1928                                                                                                                                              |  | 8. BIRTHPLACE (State or Foreign Country)<br>Virginia                                                |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Carroll County General Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Westminster                                                                                                                                                  |  | 9c. COUNTY OF DEATH<br>Carroll                                                                      |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10b. COUNTY<br>Carroll                                                                                                                                                                                                                                                                                     |                                           | 10c. CITY, TOWN OR LOCATION<br>New Windsor                                                                                                                                                          |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>2453 Marston Rd.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |                                           | 10f. ZIP CODE<br>21776                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |                                           | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>seamstress                                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br>sewing factory                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Elishie Suthard                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Estelle Heflin                                                                                                                                 |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Nancy A. Runkles                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3890 Wilderness Dr. Union Bridge, MD 21791                                                         |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Prospect Cemetery 11/17                                                                                                                                                                                                 |                                           | 20c. LOCATION — City or Town, State<br>nr. Mt. Airy, MD                                                                                                                                             |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Catherine D. Hartzler                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |                                           | 22. NAME AND ADDRESS OF FACILITY<br>D.D. Hartzler & Sons<br>New Windsor, MD                                                                                                                         |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular Aneurysm<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Aortic myocardial infarction<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                           | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |                                           | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                     |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Christine N. Naganma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |                                           | 29c. LICENSE NUMBER<br>DI 8200                                                                                                                                                                      |  | 29d. DATE SIGNED (Month, Day, Year)<br>11-14-95                                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>CHITRAKUTEDY NAGANMA 700A POOLE RD WESTMINSTER MD 21157                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 21 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br>Julia Anderson-Randall                                                                                                                                                                                                                                                        |                                           |                                                                                                                                                                                                     |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



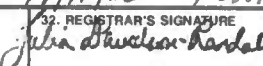




95 36486

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SOON-DUK Lee KANG</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 13, 1995</b>                                                                                                                                         |  | 3. TIME OF DEATH<br><b>11:30 A.M.</b>                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-86-4692</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.                                                                                                                                                  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 5, 1934</b>                                       |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Korea</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Suburban Hospital</b>                                                                                                                                                                                                                 |  |                                                                                                                                                                                                   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>                                          |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                     |  |                                                                                                 |  |
| 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 10c. CITY, TOWN OR LOCATION<br><b>Kensington</b>                                                                                                                                                  |  |                                                                                                 |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 10e. STREET AND NUMBER<br><b>3513 Plyers Mill Ct.</b>                                                                                                                                             |  |                                                                                                 |  |
| 10f. ZIP CODE<br><b>20895</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                       |  |                                                                                                 |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Asian</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Co-owner</b>                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Deli</b>                                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Hyung-Kyo Lee</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Soo-Jin Kang</b>                                                                                                                          |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Kyung-Koo Kang</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3513 Plyers Mill Ct. Kensington, MD 20895</b>                                                 |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, other place)<br><b>National Memorial Park</b>                                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br><b>Falls Church, VA</b>                                                                                                                                    |  | 20d. DATE<br><b>11/17/95</b>                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Every Colonial Funeral Home<br/>6161 Leesburg Pike Falls Church, VA</b>                                                                                    |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE TRAUMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>NOV 11 95</b>                                                                                                                                                                                                                                                 |  | 28b. TIME OF INJURY<br><b>12:20</b>                                                                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>HIT BY CAR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>HOME</b>                                                                                                                                                                                                      |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>#10</b>                                                                                                        |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>007099</b>                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 13 95</b>                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20817</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 01 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                  |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


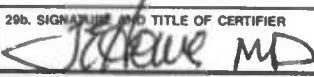

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36487

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MINNIE MARGARET LEITER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH NOVEMBER DAY 18 YEAR 1995                                                                                                                                                 |  |                                                                                      |  | 3. TIME OF DEATH<br>2:45 A M                                                                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br>219-20-2036                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>68 YRS.                                                                                                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                       |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                                                                              |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Dec. 16, 1926                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania                                                                                                                                            |  |                                                                                      |  |                                                                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Williamsport Nursing Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Williamsport                                                                                                                                                 |  |                                                                                      |  | 9c. COUNTY OF DEATH<br>Washington                                                                                                           |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                             |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. COUNTY<br>Washington                                                                                                                                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br>Hagerstown                                                                                                                                                           |  |                                                                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br>13824 Pennsylvania Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21742                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                              |  |                                                                                                                                             |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                     |  |                                                                                                                                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) unknown<br>College (1-4 or 5+) unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>medical book assembler                                                                                                                                                                    |  | 15b. KIND OF BUSINESS/INDUSTRY<br>publishing co.                                                                                                                                                    |  |                                                                                      |  |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Willis Leroy Leiter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Naomi Frick                                                                                                                                    |  |                                                                                      |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Frank Rhinehart                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>17413 Virginia Avenue, Hagerstown, Maryland 21740                                                  |  |                                                                                      |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rose Hill Cemetery                                                                                                                                                                                                      |  | DATE<br>11-20                                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br>95 Hagerstown, Maryland                       |  |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Maryland 21740                                                                                         |  |                                                                                      |  |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. VIRAL PNEUMONIA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | Approximate interval Between Onset and Death<br>DAYS                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>MULTI-INFARCT DEMENTIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                          |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                           |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>D33700                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>NOVEMBER 18, 1995                             |  |                                                                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>TED E HOWE, MD 154 N. ARTIZAN STREET, WILLIAMSPORT, MD 21795                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 20 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                    |  |                                                                                      |  |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36488

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Carrie V. Lee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH 11 DAY 15 YEAR 95                                                                                                                                                                                                                                                                |  | 3. TIME OF DEATH<br>8:45 A. M                                                                                                                                                          |  |
| 4. SOCIAL SECURITY NUMBER<br>136-22-8019                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>81 YRS.                                                                                                                                                                                                                                                                  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>8/14/14                                                                                                                                         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Virginia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Health Care Center                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick                                                                                                                                       |  |
| 9c. COUNTY OF DEATH<br>Frederick                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                     |  | 10b. COUNTY<br>Frederick                                                                                                                                                               |  |
| 10c. CITY, TOWN OR LOCATION<br>Frederick                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                        |  | 10e. STREET AND NUMBER<br>1752 Carriage Way                                                                                                                                            |  |
| 10f. ZIP CODE<br>21702                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                                                                                                                                                                                                                                             |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                                                                                                       |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7th College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Nurses Aid                                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Hospital                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Robert F. Flynn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lizzie Virginia Trenary                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Anna M. Watkins                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1752 Carriage Way Frederick, Maryland 21702                                                                                                                                                               |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Olivet Cemetery 11/18/95                                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br>Frederick, Maryland                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br>Stauffer Funeral Homes, P.A.<br>1621 Opossumtown Pike Frederick, MD 21702                                                                                                                                                                                              |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Ischemic Cardiomyopathy<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Severe C.O.P.D.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes Mellitus, Insulin dependent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                               |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 29c. LICENSE NUMBER<br>D21944                                                                                                                                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/15/95                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JAMES J. SWERISSON 1475 TANEY AVE Suite 204 Frederick, MD 21702                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 17 1995                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

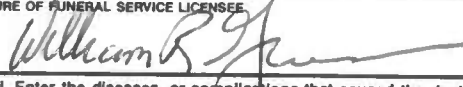
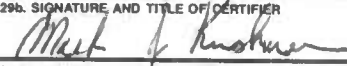

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

95 36489

Amended#'s 17 &amp; 18, 11/24/95, SW, Calvert Co.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Louis Owen LaJoice                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 13, 1995                                                                                                                                                                                                                                                        |  | 3. TIME OF DEATH<br>12:13 p m                                       |  |
| 4. SOCIAL SECURITY NUMBER<br>578-16-3438                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                              |  | 6. AGE (In yrs. last birthday)<br>72 YRS.                                                                                                                                                                                                                                                                  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Mar. 10, 1923             |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Michigan                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                             |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br>Bethesda                                                                                                                                                                                                                                                            |  | 9c. COUNTY OF DEATH<br>Montgomery                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Suburban Hospital                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                             |  | 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                     |  |                                                                     |  |
| 10b. COUNTY<br>Calvert                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br>North Beach                                                                                                                                                                                                                                                                 |  |                                                                     |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                             |  | 10e. STREET AND NUMBER<br>3912 3rd Street                                                                                                                                                                                                                                                                  |  |                                                                     |  |
| 10f. ZIP CODE<br>20714                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                       |  |                                                                     |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5 +)                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Electrician                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Construction                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Ralph Alvin Owen LaJoice                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                             |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Leona Rains Schlocomb                                                                                                                                                                                                                                 |  |                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Florence LaJoice                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>same as # 10 above                                                                                                                                                                                        |  |                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  |                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metropolitan Crematory 11-16-95 Alexandria, VA                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br>Rausch Funeral Home, P.A., Owings, MD                                                                                                                                                                                                                                  |  |                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiomyopathy</u><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                     |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                     |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                     |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                     |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                             |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  |                                                                                                                                                             |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                            |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                             |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  |                                                                     |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                             |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |  |                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                             |  | 29c. LICENSE NUMBER<br>D23468                                                                                                                                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 13, 1995            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Mark Kushner, MD 120 Hospital Road, Prince Frederick, MD 20678                                                                                                                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 17 1995                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                           |  |                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

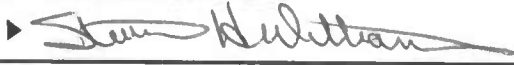

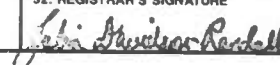




95 36490

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|--|------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Cora Madeline Lee                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 16, 1995                                                                                                                                                                                                                                         |  |                                                                                                                                       |  | 3. TIME OF DEATH<br>11:20 p.m.                                                                      |  |                                                        |  |                                                      |  |
| 4. SOCIAL SECURITY NUMBER<br>216-48-9443                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                      |  | 6. AGE (In yrs. last birthday)<br>90 YRS.                                                                                                                                                                                                                                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                        |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                                      |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 10, 1905 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Crofton Convalescent and Rehab. Center                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Crofton                                                                                        |  |                                                                                                     |  | 9c. COUNTY OF DEATH<br>Anne Arundel                    |  |                                                      |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br>Anne Arundel                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br>Annapolis                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |                                                        |  |                                                      |  |
| 10e. STREET AND NUMBER<br>511 Wilson Road                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  | 10f. ZIP CODE<br>21401                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                |  |                                                        |  |                                                      |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                             |  |                                                                                                                                       |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                    |  |                                                        |  |                                                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                     |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                                                                                                                                                                      |  |                                                                                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home                                                          |  |                                                        |  |                                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Sears                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Birtha Susannah Jones                                                            |  |                                                                                                     |  |                                                        |  |                                                      |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>John W. Lee                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>511 Wilson Road, Annapolis, MD 21401 |  |                                                                                                     |  |                                                        |  |                                                      |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                       |  |                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Fittcrest Memorial Gardens 11/20                                                                                                                                                                             |  |                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br>Annapolis, MD                                                |  |                                                        |  |                                                      |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  | 22. NAME AND ADDRESS OF FACILITY<br>John M Taylor Funeral Home, Inc.<br>147 Duke of Gloucester Street, Annapolis, MD 21401            |  |                                                                                                     |  |                                                        |  |                                                      |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                             |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Aspiration Pneumonia</u> Approximate Interval Between Onset and Death <u>2 weeks</u>                                                                                                                                                                                                                                                          |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| b. <u>Alzheimer's disease</u> 10 year                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                            |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Peripheral vascular disease</u><br><u>ischemic ulcer's feet</u>                                                                                                                                                                                                                          |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                     |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                   |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                     |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                             |  |                                                                                                                                                     |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                       |  | 28b. TIME OF INJURY<br>M                                                                                                              |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED                      |  |                                                      |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                    |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br>Dr. Paul Rhodes                                                                                                                                                                                                                                                                       |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  | 29c. LICENSE NUMBER<br>D22028                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/17/95                                                     |  |                                                        |  |                                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Paul Rhodes 1667 Crofton Center, Suite 1, Crofton, MD                                                                                                                                                                                                                                                                      |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 21 1995                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                |  |                                                                                                                                       |  |                                                                                                     |  |                                                        |  |                                                      |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HOWARD STANLEY LITTLE JR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>10</b> YEAR <b>1995</b>                                                                                                                            |  | 3. TIME OF DEATH<br><b>2341</b> M                                                           |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>216-18-4973</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>MONTH <b>DEC</b> DAY <b>14</b> YEAR <b>1918</b>                         |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ANNE ARUNDEL MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ANNAPOLIS, MARYLAND</b>                                                                                                                               |  | 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>                                                  |                                                                                                       |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>                                                                                                                                                              |  | 10c. CITY, TOWN OR LOCATION<br><b>ANNAPOLIS</b>                                             |                                                                                                       |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>1111 LAKE HERON DRIVE</b>                                                                                                                                          |  |                                                                                             |                                                                                                       |
| 10f. ZIP CODE<br><b>21403</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                  |  |                                                                                             |                                                                                                       |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES                                                                                                                                               |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>4 YRS. PLUS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>W.W. 14<br/>EDUCATION</b>                                                                                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>COLLRGE</b>                                                                                                                                                |  |                                                                                             |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HOWARD STANLEY LITTLE SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CHARLOTTE JOHNSON</b>                                                                                                                   |  |                                                                                             |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>HELEN FLORINE WILLIAMS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1231 GEMINI DR. APT E ANNAPOLIS, MD. 21403</b>                                              |  |                                                                                             |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MD. VET. CEM. NOV. 16-1995</b>                                                                                                                                                                           |  | DATE                                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br><b>CROWNSVILLE, MD.A.A.CO</b>                        |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>CHARLES E. HICKS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ANNAPOLIS, MARYLAND<br/>HOUSE OF HICKS 1922 FOREST DRIVE - 21401</b>                                                                                     |  |                                                                                             |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Ischemic</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Coronary Atherosclerosis</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             | Approximate Interval Between Onset and Death<br><b>24 HRS</b>                                         |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Michael</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>3550768424</b>                                                                                                                                                        |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/20/91</b>                                      |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>2003 Medical Parkway Annapolis MD 21401</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 24 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>                                                                                                                                                 |  |                                                                                             |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                             |                                                                                                                                                                                                     |                                                  |                                                                                      |                                                                                                           |                                                                                                     |                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>William J. Lane</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                             | 2. DATE OF DEATH<br>MONTH <u>11</u> DAY <u>19</u> YEAR <u>95</u>                                                                                                                                    |                                                  | 3. TIME OF DEATH<br><u>2225 PM</u>                                                   |                                                                                                           |                                                                                                     |                                                                                                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><u>213-16-9994</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |                                                                                                                             | 6. AGE (In yrs. last birthday)<br><u>87</u> YRS.                                                                                                                                                    |                                                  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>9/26/1908</u>                              |                                                                                                           | 8. BIRTHPLACE (State or Foreign Country)<br><u>Pennsylvania</u>                                     |                                                                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Center Veterans Administration Med.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                             | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>                                                                                                                                             |                                                  |                                                                                      | 9c. COUNTY OF DEATH<br><u>Baltimore</u>                                                                   |                                                                                                     |                                                                                                                                             |  |
| 10a. STATE<br><u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            | 10b. COUNTY<br><u>Harford</u>                                                                                               |                                                                                                                                                                                                     | 10c. CITY, TOWN OR LOCATION<br><u>Darlington</u> |                                                                                      |                                                                                                           | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                             |  |
| 10e. STREET AND NUMBER<br><u>4136 Flintville Road</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                             | 10f. ZIP CODE<br><u>21034</u>                                                                                                                                                                       |                                                  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>United States</u>                                |                                                                                                           |                                                                                                     |                                                                                                                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><u>World War II</u>                                                                                                                                    |                                                                                                                             | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                                  |                                                                                      | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>White</u>                                |                                                                                                     |                                                                                                                                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>Unknown</u><br>College (1-4 or 5+) <u></u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Farmer</u> |                                                                                                                                                                                                     |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Agriculture</u>                                 |                                                                                                           |                                                                                                     |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>William Howard Lane</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                             | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Zua Lena Boyd</u>                                                                                                                           |                                                  |                                                                                      |                                                                                                           |                                                                                                     |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Vera Sala</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                             | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2005 Wintergreen Place Baltimore, MD 21237</u>                                                  |                                                  |                                                                                      |                                                                                                           |                                                                                                     |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Mt. Nebo Cemetery</u>                                                                                                                                                                                                |                                                                                                                             | DATE<br><u>11/22</u>                                                                                                                                                                                |                                                  | 20c. LOCATION — City or Town, State<br><u>Delta, PA</u>                              |                                                                                                           |                                                                                                     |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Stephany P. Lovelidge</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                             | 22. NAME AND ADDRESS OF FACILITY<br><u>Harkins Funeral Home, Inc. Delta, PA</u>                                                                                                                     |                                                  |                                                                                      |                                                                                                           |                                                                                                     |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Perforated abdominal viscous</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u></u> DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u></u> DUE TO (OR AS A CONSEQUENCE OF):<br>d. <u></u><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                             |                                                                                                                                                                                                     |                                                  |                                                                                      | Approximate Interval Between Onset and Death                                                              |                                                                                                     |                                                                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></u>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                             |                                                                                                                                                                                                     |                                                  |                                                                                      | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                             |                                                                                                                                                                                                     |                                                  |                                                                                      |                                                                                                           |                                                                                                     |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                                                                                                             | 28b. TIME OF INJURY<br><u>M</u>                                                                                                                                                                     |                                                  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                           | 28d. DESCRIBE HOW INJURY OCCURRED                                                                   |                                                                                                                                             |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |                                                                                                                             |                                                                                                                                                                                                     |                                                  |                                                                                      |                                                                                                           |                                                                                                     |                                                                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                             |                                                                                                                                                                                                     |                                                  |                                                                                      |                                                                                                           |                                                                                                     |                                                                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Brett W. Engbrecht MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                             |                                                                                                                                                                                                     | 29c. LICENSE NUMBER<br><u>520648</u>             |                                                                                      | 29d. DATE SIGNED (Month, Day, Year)<br><u>11/19/95</u>                                                    |                                                                                                     |                                                                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Brett W. Engbrecht MD 22 S. Greene St, Baltimore, MD 21201</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |                                                                                                                             |                                                                                                                                                                                                     |                                                  |                                                                                      |                                                                                                           |                                                                                                     |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><u>NOV 21 1995</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><u>Jana Davidson-Randall</u>                                                                                                                                                                                                                                                  |                                                                                                                             |                                                                                                                                                                                                     |                                                  |                                                                                      |                                                                                                           |                                                                                                     |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36493

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                           |  |                                                                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Albert Luther</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>16</b> YEAR <b>1995</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                           |  | 3. TIME OF DEATH<br><b>1320</b>                                                                                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-48-8301</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                       |  | 6. AGE (In yrs. last birthday)<br><b>47</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                 |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                                                          |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                                                                                                       |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>March 8, 1948</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                           |  |                                                                                                                                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                           |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>                                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 10b. COUNTY<br><b>Dorchester</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>Secretary</b>                                                                                                           |  |                                                                                                                                                        |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | 10e. STREET AND NUMBER<br><b>104 Main Street</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 10f. ZIP CODE<br><b>21664</b>                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                                                                                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                   |  |                                                                                                                                                        |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Truck Driver</b>             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Seafood Co.</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                           |  |                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Albert Luther Lewis, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mabel Willey</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                           |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Barbara M. Lewis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 361 Secretary, Maryland 21664</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                           |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)<br><b>St. Paul's P.E. Cemetery</b>                             |  | DATE<br><b>11/20</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br><b>Vienna, Maryland</b>                                                                                            |  |                                                                                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Thomas Funeral Home, P.A.<br/>700 Locust St. Cambridge, Maryland 21613</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                           |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBRAL VASCULAR ACCIDENT</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>RIGHT MIDDLE CEREBRAL ARTERY EMBOLUS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate interval Between Onset and Death<br><b>2 days</b><br><b>2 days</b><br><b>years</b> |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                           |  |                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                           |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                           |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Sudden 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                    |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                        |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                    |  |                                                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Nicholas L. Ogburn MD.</b>                                                                                    |  |                                                                                                                                                        |  |
| 29c. LICENSE NUMBER<br><b>34593</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/95</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NICHOLAS L. OGBURN 201 PINE BLUFF ROAD SALISBURY, MD. 21801</b> |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 22 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                           |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


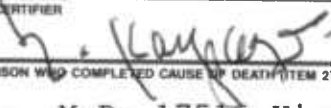




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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Donald Milford McCauley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>17</b> , YEAR <b>1995</b>                                                                                                                      |  | 3. TIME OF DEATH<br><b>4.00A<sup>M</sup></b>                                                    |                                                                                                                                          |
| 4. SOCIAL SECURITY NUMBER<br><b>216-22-1977</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan. 17, 1915</b>                                  |                                                                                                                                          |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>12 S. Walnut St. #209</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>                                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>Washington</b>                                                        |                                                                                                                                          |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                          |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br><b>Washington</b>                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                          |
| 10e. STREET AND NUMBER<br><b>12 S. Walnut Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21740</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                                                          |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>W.W. II</b>                                                                                                                                 |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                      |                                                                                                                                          |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do not use retired.)<br><b>truck driver</b>                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>moving and storage</b>                                     |                                                                                                                                          |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Howard McCauley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nora Showe</b>                                                                                                                          |  |                                                                                                 |                                                                                                                                          |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Denton L. McCauley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16744 Buford Ave., Williamsport, Md. 21795</b>                                              |  |                                                                                                 |                                                                                                                                          |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hagerstown Crematory 11-17-95</b>                                                                                                                                                                        |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>                                                                                                                              |  |                                                                                                 |                                                                                                                                          |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME<br/>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>                                                                                  |  |                                                                                                 |                                                                                                                                          |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>Cardiorespiratory arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Acute Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>ASCVD With Chronic Atrial Fibrillation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death<br><br><b>few hrs</b><br><br><b>years</b>                                                   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Severe COPD, Diabetes Mellitus</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                    |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                          |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |                                                                                                                                          |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                                 |                                                                                                                                          |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                          |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Wun B. Kang, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D17027</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/95</b>                                          |                                                                                                                                          |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Wun B. Kang, M.D., 17516 Virginia Ave., Hagerstown, Md. 21740</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                          |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 20 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                          |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


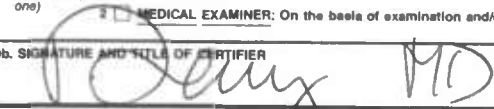
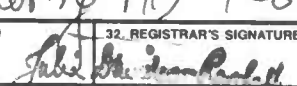
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36495

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>James William Myers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 11, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>4:00 P M</b>                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-16-3532</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 23, 1924 MD.</b>                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>12427 Big Pool Rd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Clear Spring,</b>                                                                                                                                     |  | 9c. COUNTY OF DEATH<br><b>Washington</b>                                                    |  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Washington</b>                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Clear Spring</b>                                          |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>12427 Big Pool Road</b>                                                                                                                                            |  |                                                                                             |  |
| 10f. ZIP CODE<br><b>21722</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                                                                                   |  |                                                                                             |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                     |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 yrs.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Carpenter</b>                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Contractor</b>                                                                                                                                             |  |                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Grover Cleveland Myers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Kitty Wilamena Weaver</b>                                                                                                               |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary R. Myers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12427 Big Pool Rd. Clear Spring, MD 21722</b>                                               |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory Nov. 12, 1995</b>                                                                                                                                                                   |  | 20c. LOCATION — City or Town, State<br><b>Smithsburg, MD</b>                                                                                                                                    |  |                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Thompson Funeral Home, Inc.<br/>P.O. Box 310 Clear Spring, MD 21722</b>                                                                                  |  |                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>e. Metastatic brain carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Pulmonary Disease</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                             |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D 41786</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/95</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. Henchey MD 12821 Dale Hill Avenue, Hagerstown MD 21740</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 15 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36496

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                                           |  |                                |  |                                                                                                          |  |                                                                                                                |  |                                                                                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------|--|----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Paul Brill MIMNALL, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                       |                                                  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 13 1995</b>                                                                                                                                                                                                                                                             |  |                                |  | 3. TIME OF DEATH<br><b>2355 M</b>                                                                        |  |                                                                                                                |  |                                                                                                                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-09-0176</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                   | 6. AGE (In yrs. last birthday)<br><b>96</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                                                                                                                                            |  | IF UNDER 24 HRS.<br>HOURS MIN. |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan. 3, 1899</b>                                            |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>                                                |  |                                                                                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>                                                                                                                                                                                                                                                                  |  |                                |  | 9c. COUNTY OF DEATH<br><b>Washington</b>                                                                 |  |                                                                                                                |  |                                                                                                                                                             |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                                           |  |                                |  |                                                                                                          |  |                                                                                                                |  |                                                                                                                                                             |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. COUNTY<br><b>Washington</b>                                                                                                                      |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>                                                                                                                                                                                                                                                                          |  |                                |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |                                                                                                                |  |                                                                                                                                                             |  |
| 10e. STREET AND NUMBER<br><b>10834 Downsville Pike, Apt. 2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |                                                  | 10f. ZIP CODE<br><b>21740</b>                                                                                                                                                                                                                                                                                             |  |                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                              |  |                                                                                                                |  |                                                                                                                                                             |  |
| 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                  |  |                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                               |  |                                                                                                                |  |                                                                                                                                                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>6</b> Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                       |                                                  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>plant manager</b>                                                                                                                                                                                     |  |                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>oil company</b>                                                     |  |                                                                                                                |  |                                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Ellsworth Mimmall</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                       |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Marie Brill</b>                                                                                                                                                                                                                                              |  |                                |  |                                                                                                          |  |                                                                                                                |  |                                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Harry E. Mimmall</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18005 Oak Ridge Dr., Hagerstown, Maryland 21740</b>                                                                                                                                                                   |  |                                |  |                                                                                                          |  |                                                                                                                |  |                                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |                                                  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery 11-17-95</b>                                                                                                                                                                                                    |  |                                |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>                                       |  |                                                                                                                |  |                                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott Mimmall</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME<br/>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>                                                                                                                                                                                                            |  |                                |  |                                                                                                          |  |                                                                                                                |  |                                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cerebrovascular accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Coronary artery disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                                           |  |                                |  |                                                                                                          |  | Approximate Interval Between Onset and Death                                                                   |  |                                                                                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                                           |  |                                |  |                                                                                                          |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                                           |  |                                |  |                                                                                                          |  |                                                                                                                |  |                                                                                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                       |                                                  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Extended care facility</b> |  |                                |  |                                                                                                          |  |                                                                                                                |  |                                                                                                                                                             |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><b>2</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                       |                                                  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                                 |  | 28b. TIME OF INJURY<br>M       |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                              |  |                                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |                                                  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                    |  |                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                             |  |                                                                                                                |  |                                                                                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                     |  |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                                           |  |                                |  |                                                                                                          |  |                                                                                                                |  |                                                                                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John L. Coppes</i> M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                                  | 29c. LICENSE NUMBER<br><b>P41031</b>                                                                                                                                                                                                                                                                                      |  |                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/14/95</b>                                                   |  |                                                                                                                |  |                                                                                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>Harry E. Coppes Washington County Hospital Hagerstown, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |                                                  |                                                                                                                                                                                                                                                                                                                           |  |                                |  |                                                                                                          |  |                                                                                                                |  |                                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 15 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                       |                                                  | 32. REGISTRAR'S SIGNATURE<br><i>John L. Coppes</i>                                                                                                                                                                                                                                                                        |  |                                |  |                                                                                                          |  |                                                                                                                |  |                                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020


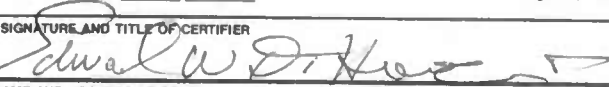
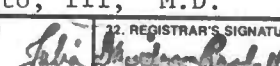
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36497

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELEANORA MNM MCCUBBIN</b>                                                                                                                                                                                                                  |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 13, 1995</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 3. TIME OF DEATH<br><b>3:55 AM</b>                                                                                                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-60-4371</b>                                                                                                                                                                                                                                           |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                 |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 5, 1911</b>                                                                                                                             |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                               |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>                                                                                                                                                                                                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>                                                                                                                               |  |
| 9c. COUNTY OF DEATH<br><b>Washington</b>                                                                                                                                                                                                                                                  |  |                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>Washington</b>                                                                                                                                                       |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>                                                                                                                                                                                                                                          |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>10128 Sharpsburg Pike</b>                                                                                                                                 |  |
| 10f. ZIP CODE<br><b>21740</b>                                                                                                                                                                                                                                                             |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                          |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  |                                                                                                                                                                                        |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                                                                                                                                                                                                                |  |                                                                                |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>housewife</b>                                                                                                                                                            |  |                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>her own home</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Wesley Avey Bowman</b>                                                                                                                                                                                                                 |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma M. Seibert</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Thomas L. McCubbin</b>                                                                                                                                                                                                                           |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1912 Applewood Dr., Hagerstown, Maryland 21740</b>                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                           |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery 11-16-95</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>                                                                                                                                                                                                                        |  |                                                                                |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME</b>                                                                                                                                                                                                                           |  |                                                                                |  | 415 E. Wilson Blvd., Hagerstown, Md. 21740                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                 |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| a. <u>Ruptured Thoracic Aortic Aneurysm</u> moments                                                                                                                                                                                                                                       |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| b. <u>Arteriosclerotic Cardio Vascular Disease</u> many years                                                                                                                                                                                                                             |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| c. _____                                                                                                                                                                                                                                                                                  |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| d. _____                                                                                                                                                                                                                                                                                  |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                    |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                       |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                 |  |                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                     |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                           |  |                                                                                |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                         |  |                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                              |  |                                                                                |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                              |  |                                                                                |  | 29c. LICENSE NUMBER<br><b>DO1062</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                        |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>November 14, 1995</b>                                                                                                                                                                                                                           |  |                                                                                |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD. 21740</b>                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 15 1995</b>                                                                                                                                                                                                                                   |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.









95 36499

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Marjorie C. Martin</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 15, 1995</b>                                                                                                                                                                                                                                 |  | 3. TIME OF DEATH<br><b>4:01 PM</b>                                                                                                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-26-2373</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 5, 1924</b>                                                                                                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington, D.C.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>                                                                                                                        |  |
| 9c. COUNTY OF DEATH<br><b>Frederick</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><b>Frederick</b>                                                                                                                                                |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>8215 Glendale Drive</b>                                                                                                                           |  |
| 10f. ZIP CODE<br><b>21702</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                                                                                                                          |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                        |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Analyst</b>                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Government</b>                                                                                                                            |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Whitman P. Conn</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alys Monk</b>                                                                                                                                                                                                                          |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert T. Martin</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8215 Glendale Drive Frederick, MD 21702</b>                                                                                                                                                |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Resthaven Mem. Gardens 11/18/95</b>                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland</b>                                                                                                              |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Stauffer Funeral Homes, P.A.<br/>1621 Opossumtown Pike Frederick, MD 21702</b>                                                                                                                                                                          |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>acute Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. <b>acute Myocardial Infarction</b><br>b. <b>DUE TO (OR AS A CONSEQUENCE OF):</b><br>c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b><br>d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Fracture of femur, stroke</b><br><b>Severe coronary artery disease</b><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                  |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                         |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>D21648</b>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/95</b>                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kusay BARAKAT 310 W 9th Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 36500

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Arthur William Moore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 15, 1995</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>8:07 pm</b>                                                              |                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br><b>217-12-1900</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>March 22, 1920</b>                                 |                                                                                                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>                                                         |                                                                                                                                             |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                                                                                             |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. COUNTY<br><b>Frederick</b>                                                                                                                                                        |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                             |
| 10e. STREET AND NUMBER<br><b>1404 Pinewood Drive</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  | 10f. ZIP CODE<br><b>21701</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |                                                                                                                                             |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Jan. 12, 1943-Mar. 23, 1946</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |                                                                                                                                             |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Self Employed Barber</b>                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Barbering/Hair Care</b>                                                                                                                                        |  |                                                                                                 |                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Merhl Moore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maude Stull</b>                                                                                                                             |  |                                                                                                 |                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Alma R. Moore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1404 Pinewood Drive, Frederick, Maryland 21701</b>                                              |  |                                                                                                 |                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Resthaven Memorial Gardens, Nov. 18, 1995</b>                                                    |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland</b>                                                                                                                                   |  |                                                                                                 |                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Richard E. Trof</b> M00255                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford P.A. Funeral Home<br/>106 East Church St., Frederick, Md. 21701</b>                                                                       |  |                                                                                                 |                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hypocalcemia</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Metastatic Squamous cell carcinoma</b><br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                 | Approximate interval between Onset and Death<br><b>5 days</b>                                                                               |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                                                                                             |
| HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                   |  |                                                                                                 |                                                                                                                                             |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                          |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                 |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |                                                                                                                                             |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                 |                                                                                                                                             |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                 |                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Allen S. Gibson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  | 29c. LICENSE NUMBER<br><b>D26516</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 16 1995</b>                                       |                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Allen S. Gibson 1475 TANEY AVE FRED MD 21702</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1995</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  | 32. REGISTRAR'S SIGNATURE<br><b>Shawna Randall</b>                                                                                                                                                  |  |                                                                                                 |                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000-01-12

2000-01-12  
10:00 AM

2000-01-12  
10:00 AM